Family History

Please check all of the following that apply for any family member: Next to the disorder please name what relation the person is to you, i.e. Mom, Dad, etc.

☐ Uterine Cancer _____	☐ Colon/Retal Cancer _____
☐ High Blood Pressure _____	☐ Diabetes _____
☐ Fibroids _____	☐ Birth Defects _____
☐ Breast Cancer _____	☐ Down Syndrome _____
☐ Bleeding/Clotting Disorders _____	☐ Heart Disease _____
☐ Arthritis/Autoimmune Dissorders (Muscle, Skin, Bone, Joint Disease, Lupus) _____	☐ Seizures/Epilespy _____
☐ Endometriosis _____	☐ Miscarriages _____
☐ DES Exposure _____	☐ Ovarian Cancer _____
☐ Deafness before the age 60 _____	☐ Loss of Muscle Coordination (Huntington's Cborea) _____
☐ Cleft Lip/Palate _____	☐ Club Foot _____
☐ Neural Tube Defects _____ (Spina Bifida)	☐ Cystic Fibrosis _____
☐ Sickle Cell Anemia _____	☐ Thalassemia _____
☐ Kidney Disease _____	☐ Premature Ovarian Failure (Menopause) _____
☐ Nervous System Disease _____	☐ Cataracts before age 40 _____
☐ Prostate Cancer _____	☐ Schizophrenia _____
☐ Manic Depression (Psychosis) _____	☐ Mental Illness _____
☐ Congenital Heart Disease _____	☐ Pyloric Stenosis _____

Please add any other family health history that you think is significant on the back of this sheet.