Name of recorder:

Date recorded:

Name of person :

Relationship:

Person’s Date of birth:

Ethnicity/ancestry:

Known health problems: (check all that apply)

Disease/Health Issue Age of Onset

* Alzheimer’s disease/dementia
* Asthma and/or allergies
* Birth defect (heart defect, cleft lip, spina bifida)
* Vision loss/deafness
* Hearing loss, deafness
* Cancer (breast, ovarian, colon, prostate, etc)
* Developmental delay/learning issues/Autism
* Diabetes (I or II)/”sugar” disease
* Heart disease/conduction defects
* High blood pressure
* Elevated cholesterol levels
* History of surgeries
* Mental health disorders (depression, schizophrenia, etc)
* Obesity
* No. of pregnancies a woman had, including miscarriage

And/or stillbirth

* Pregnancy complications (prematurity, eclampsia)
* Stroke/seizures
* Substance abuse (alcohol, drugs)
* Medication use/reactions
* Genetic disease
* Sudden death
* Other (explain)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If deceased, list cause of death?

Age at death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of questions and/or concerns based on the person’s health/medical history:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_