
MEDICAL HISTORY FORM

Name of Ancestor and Relationship

DATE AND PLACE OF BIRTH.....

SINGLE/MULTIPLE BIRTH AND BIRTH ORDER.....

BIRTHMARKS.....

BIRTH COMPLICATIONS.....

BIRTH DEFECTS (including blind, deaf, mute).....

CONGENITAL DEFECTS.....

CHILDHOOD DISEASES

..... date..... complications.....
..... date..... complications.....
..... date..... complications.....
..... date..... complications.....

MAJOR ILLNESSES

..... date..... complications.....
..... date..... complications.....
..... date..... complications.....
..... date..... complications.....

OTHER DISEASES

.....
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.....

MAJOR INJURIES

..... date..... complications.....
..... date..... complications.....
..... date..... complications.....

SURGERIES

..... date..... complications.....

SURGERIES, CONT'D

..... date..... complications.....
..... date..... complications.....

ALLERGIES (food and other)

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ALLERGIES (medicines)

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MENTAL ILLNESS (type/attempted suicide)

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HEREDITARY DISEASES

Family member..... Disease.....
Family member..... Disease.....
Family member..... Disease.....
Family member..... Disease.....

DATE AND PLACE OF DEATH..... AGE.....

CAUSE(S) OF DEATH.....

FACTORS CONTRIBUTING TO DEATH.....

PHYSICAL DESCRIPTION

COLOR OF HAIR..... EYE COLOR.....

RACE/ETHNICITY.....

HEIGHT IN FEET/INCHES..... WEIGHT IN POUNDS.....

HABITS cigarettes [] cigars [] pipe [] alcohol [] drugs [] other [] alcoholic [] drug addict []

ADDITIONAL INFORMATION

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