DeWitz Family Medicine PLLC

Heartfelt care for the whole family

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Family History

Patient name__________________________Date__________________Signature______________________________

Please indicate if any of your family members had any of the following problems.

Condition	Father	Which member of father's family	Mother	Which member of mother's family?	Sibling	Child
ADD						
Alcoholism						
Allergies						
Alzheimer's						
Asthma						
Anemia						
Arthritis						
Blood diseases						
Cancer (specify)						
Cardiovascular disease						
Colon polyps						
Coronary artery disease						
Depression						
Developmental Delay						
Diabetes						
Elevated lipids						
Emphysema						
Genetic disease (specify)						
Glaucoma						
Hearing loss						
Heart Disease						
Hypertension						
Irritable bowel syndrome						
Kidney disease or stones						
Mental illness						
Migraines						
Osteoporosis						
PAD						
Seizures						
Skin conditions (specify)						
Stroke						
Thyroid disorders (specify)						
Anything else you would like to add?						