Disease Checklist

Name	Family Disease Checklist	Date

Please start this family history by telling us about health problems that you may have in your family.

Are you ADOPTED? ☐ yes. If so complete the following items only for any of your BIOLOGICAL family members

If you are filling this out for your child please indicate here -> ☐ yes and fill it out as if "you" were your child

	You	Mother	Father	Children	Brothers or Sisters	Uncle or Aunt	Father's Parents	Mother's Parents
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease or Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐
Any Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Uterine (Uterus) Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Colon or Rectal Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer_____	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer_____	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Chronic Infections	☐	☐	☐	☐	☐	☐	☐	☐
Clotting Problems	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes (type I)	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes (type II)	☐	☐	☐	☐	☐	☐	☐	☐
Down Syndrome	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐	☐	☐	☐
Hemochromatosis or "Iron Overload"	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Infertility	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Trouble (Renal Dx)	☐	☐	☐	☐	☐	☐	☐	☐
Memory Loss/Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐	☐
Neurofibromatosis,	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis or "hip fracture"	☐	☐	☐	☐	☐	☐	☐	☐
PKU or "metabolic" disease at birth	☐	☐	☐	☐	☐	☐	☐	☐
Sickle Cell Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Smoking	☐	☐	☐	☐	☐	☐	☐	☐
Stillbom/Infant Death	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Violence/Domestic Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐

Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐