TAHOE FOREST
MULTISPECIALTY CLINICS

New Patient Family Medical History Questionnaire

*Please **specify** which relative (i.e. mother/father, brother/sister, aunt/uncle, grandmother/grandfather) as well as maternal and/or paternal.*

Patient's Name: _____ DOB: _____ Sex: _____

- Allergies? (Medications, foods, animals, etc.) _____

  _____
- Tobacco use by any family members? Yes _____ No_____ Inside/Outside use? _____
- Has the patient had any hospitalizations or surgeries? _____

  _____
- Asthma - Yes _____ No_____ Relation _____
- Diabetes - Yes _____ No_____ Relation _____
- High blood pressure - Yes _____ No_____ Relation _____
- High cholesterol - Yes _____ No_____ Relation _____
- Congenital heart disease - Yes _____ No_____ Relation _____
- Sudden cardiac death before age 50 - Yes _____ No_____ Relation _____
- Stroke - Yes _____ No_____ Relation _____
- Cancer - Yes _____ No_____ Relation _____
- Mental health problems - Yes _____ No_____ Relation _____
- Alcohol/Drug abuse - Yes _____ No_____ Relation _____
- Other pertinent family history? _____

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Parent or Guardian Signature _____ Date _____