My Family Health History

Fill in the blanks below for each of your immediate family members. Looking at their health history can give you information about your own health and habits. Think of health conditions such as high blood pressure, high blood cholesterol, diabetes, overweight, heart attack, and stroke that affect your family members.

Maternal (from your mom's side)

Grandmother

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

Grandfather

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

Mother

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

Paternal (from your dad's side)

Grandmother

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

Grandfather

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

Father

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

Sibling

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

You

Name:_____
Age: _____
Health conditions: _____
_____
_____
_____
_____
_____

Sibling

Name:_____
Age: _____
Health conditions: _____
_____
_____
Has this person passed away?:
☐ Yes ☐ No
If yes, at what age?_____
How? _____

My Family Health History

Sibling	Sibling	Sibling
Name:________________ Age: ________________ Health conditions: __________ ____________________ ____________________ Has this person passed away?: ☐ Yes ☐ No If yes, at what age?__________ How? ________________	Name:________________ Age: ________________ Health conditions: __________ ____________________ ____________________ Has this person passed away?: ☐ Yes ☐ No If yes, at what age?__________ How? ________________	Name:________________ Age: ________________ Health conditions: __________ ____________________ ____________________ Has this person passed away?: ☐ Yes ☐ No If yes, at what age?__________ How? ________________

Sibling	Sibling	Sibling
Name:________________ Age: ________________ Health conditions: __________ ____________________ ____________________ Has this person passed away?: ☐ Yes ☐ No If yes, at what age?__________ How? ________________	Name:________________ Age: ________________ Health conditions: __________ ____________________ ____________________ Has this person passed away?: ☐ Yes ☐ No If yes, at what age?__________ How? ________________	Name:________________ Age: ________________ Health conditions: __________ ____________________ ____________________ Has this person passed away?: ☐ Yes ☐ No If yes, at what age?__________ How? ________________

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

NIH National Heart, Lung, and Blood Institute

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