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? ______________

National Heart, Lung, and Blood Institute

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