Please place a check mark by the family member with the problem. (Maternal= Mom's side,Paternal= Dad's side)

Name:

	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER
ANEMIA								
ARTHRITIS								
ASTHMA								
BREAST CANCER								
CVA (stroke)								
CANCER								
COLON CANCER								
COPD								
DEEP VEIN THROMBOSIS								
DEPRESSION								
DIABETES								
EYE DISORDER								
GASTRIC ULCER								
HEART DISEASE								
HEMOPHILIA								
HYPERLIPIDEMIA (high cholesterol)								
HYPERTENSION (high blood pressure)								
LIVER DISEASE								
MENTAL ILLNESS								
PULMONARY EMBOLISM								
SEIZURE								
SKIN DISORDER								
SUBSTANCE ABUSE								
THYROID DISORDER								
UROGENITAL DISORDER (kidney/bladder)								
Alcohol Use								
Substance Use								
Tobacco Use								