MEDICAL HISTORY FORM FOR FAMILIES

A simple way to share your family's health story

How to use this form
Fill in what you know. It is okay to leave a space blank or write "not sure." Ask relatives about health conditions and the age when each condition started. Bring the completed form to your healthcare visit.

A note about family health
Your family history can help guide your care, but it does not predict your future. Health is also affected by where people live, work, learn, and receive care. This form lists conditions that are important for many families, including conditions that may place a greater health burden on Black/African American communities. Anyone can have these conditions.

1. About You

Name **Date of birth**

Today's date **Best phone number**

Healthcare professional **Healthcare professional's phone**

☐ This form is for me ☐ I am filling it out with or for:

☐ Black/African American ☐ African ☐ Afro-Caribbean ☐ Multiracial ☐ Another identity:
Prefer not to answer

2. Heart and Blood Sugar Health

Check all that apply. If you are not sure, check "Not sure."

Health condition	Me	Family	Not sure	Who / age / notes
High blood pressure	☐	☐	☐	
Heart disease or heart attack	☐	☐	☐	
Stroke or "mini-stroke" (TIA)	☐	☐	☐	
High cholesterol	☐	☐	☐	
Type 2 diabetes or prediabetes	☐	☐	☐	
Weight-related health concerns	☐	☐	☐	
Poor blood flow in the legs	☐	☐	☐	

Health condition	Me	Family	Not sure	Who / age / notes
Blood clots or a blood-clotting condition	☐	☐	☐	

3. Kidney, Blood, and Immune Health

Check all that apply. If you are not sure, check "Not sure."

Health condition	Me	Family	Not sure	Who / age / notes
Kidney disease or kidney failure	☐	☐	☐	
Dialysis or kidney transplant	☐	☐	☐	
Sickle cell disease	☐	☐	☐	
Sickle cell trait	☐	☐	☐	
Anemia (low red blood cells)	☐	☐	☐	
Lupus or another immune-system condition	☐	☐	☐	

4. Cancer History

Check all that apply. If you are not sure, check "Not sure."

Health condition	Me	Family	Not sure	Who / age / notes
Breast cancer	☐	☐	☐	
Prostate cancer	☐	☐	☐	
Colon or rectal cancer	☐	☐	☐	
Multiple myeloma or another blood cancer	☐	☐	☐	
Pancreatic cancer	☐	☐	☐	
Ovarian cancer	☐	☐	☐	
Lung cancer	☐	☐	☐	
Another cancer:	☐	☐	☐	

5. Other Health Conditions

Check all that apply. If you are not sure, check "Not sure."

Health condition	Me	Family	Not sure	Who / age / notes

Health condition	Me	Family	Not sure	Who / age / notes
Asthma or another long-term lung condition	☐	☐	☐	
Glaucoma or serious vision loss	☐	☐	☐	
Liver disease	☐	☐	☐	
Depression, anxiety, or another mental health condition	☐	☐	☐	
Dementia or Alzheimer's disease	☐	☐	☐	
Another condition that runs in the family:	☐	☐	☐	

6. Pregnancy and Birth History (if this applies)

Check all that apply. If you are not sure, check "Not sure."

Health condition	Me	Family	Not sure	Who / age / notes
High blood pressure during pregnancy or preeclampsia	☐	☐	☐	
Diabetes during pregnancy	☐	☐	☐	
Baby born early (preterm birth)	☐	☐	☐	
Heart problem during or after pregnancy	☐	☐	☐	
Serious problem during pregnancy or childbirth	☐	☐	☐	
Pregnancy-related death in the family	☐	☐	☐	

7. Your Family Health Story

Write the main health conditions for each biological relative, when known. Approximate ages are okay.

Family member	Main health conditions	Age when it started	Notes / cause of death
Mother			
Father			

Family member	Main health conditions	Age when it started	Notes / cause of death
Mother's mother			
Mother's father			
Father's mother			
Father's father			
Sister(s) / brother(s)			
Child(ren)			
Aunt(s) / uncle(s)			

8. Health Checks and Screening

Your healthcare professional can help decide which checks are right for you and when you need them.

Health check	Date	Result	Next step / due date
Blood pressure			
Blood sugar or A1C			
Cholesterol			
Kidney check			
Breast cancer screening			
Cervical cancer screening			

Health check	Date	Result	Next step / due date
Colon and rectal cancer screening			
Prostate cancer conversation / screening			
Eye exam / glaucoma check			
Other:			

9. Medicines, Allergies, and Help You May Need

Current medicines and vitamins:

_____

_____

Medicine or food allergies:

_____

_____

Help needed with transportation, food, insurance, cost, housing, or follow-up care:

_____

_____

10. Questions for Your Healthcare Professional

☐ Does my family history change the health checks I need or when I should start them?

☐ Should I meet with a genetic counselor or ask about genetic testing?

☐ What do my blood pressure, blood sugar, cholesterol, and kidney results mean?

☐ What symptoms should I call about right away?

☐ What is one step I can take now to protect my health?

☐ Are there low-cost or local resources that can help me follow the care plan?

11. My Next Steps

My most important health goal:

Visit or health check I will schedule:

Family member I will talk with:

Question I want answered:

Healthcare Professional Review (Optional)

Reviewed by

Date

Main follow-up

Referral or test

Education or resources shared

Next review date.

Important: This form does not diagnose a health condition and is not for emergencies. For severe or sudden symptoms, seek immediate medical help. Talk with a qualified healthcare professional about screening, testing, and treatment choices.

For Organizations Using This Form

This educational form should receive clinical, legal, privacy, accessibility, cultural, and organizational review before it is shared publicly or added to a medical record.