



FAMILY HISTORY

Date:	
Treating Physician:	
Patient's full name :	
Lab Code:	

Paternal Family (Nationality) _____

Grandmother	Grandfather
Birth date (or date of death) _____	Birth date (or date of death): _____
Diagnosis date: _____	Diagnosis date: _____
Disease: _____	Disease: _____

Aunt	Uncle	Aunt	Uncle	Aunt	Uncle	Aunt	Uncle
Birth date or death date _____	_____	_____	_____	_____	_____	_____	_____
Diagnosis date: _____	_____	_____	_____	_____	_____	_____	_____
Disease: _____	_____	_____	_____	_____	_____	_____	_____

Maternal Family (Nationality) _____

Grandmother	Grandfather
Birth date (or date of death): _____	Birth date (or date of death): _____
Diagnosis date: _____	Diagnosis date: _____
Disease: _____	Disease : _____

Mother	Aunt	Uncle	Aunt	Uncle	Aunt	Uncle	Uncle
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Instructions: Please fill in the information for ALL FAMILY MEMBERS regardless of whether they have a disease or not, being sure to indicate their gender.

For further relatives please use the back of the form or a new form. If a member has deceased, please add a "d" in front of the date of death (e.g. d.79). Please complete the form for both sides of the family.

Husband	Examinee	Brother	Brother
Birth date: (or date of death) _____	_____	_____	_____
Diagnosis date: _____	_____	_____	_____
Disease: _____	_____	_____	_____

Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Son	Daughter	Son	Daughter	Son	Daughter	Son	Daughter
Birth date: (or date of death): _____	_____	_____	_____	_____	_____	_____	_____
Diagnosis date: _____	_____	_____	_____	_____	_____	_____	_____
Disease: _____	_____	_____	_____	_____	_____	_____	_____

Examinee
Findings of Imaging Examinations
Findings from Other Examinations