**COLONIAL MEDCARE, P.C.**
**FAMILY HISTORY FORM**

Patient's Name: _____ DOB: _____

*Is there a family history of any of the below?*

| | YES (Please list relation) | NO |
|---|---|---|
| CANCER | | |
| DIABETES | | |
| HIGH BP | | |
| HIGH CHOLESTEROL | | |
| HEART DISEASE | | |
| STROKE | | |
| ARTHRITIS | | |
| ANEMIA | | |
| ASTHMA | | |
| ALCOHOLISM | | |
| EPILEPSY | | |
| MIGRAINE | | |
| HAY FEVER | | |
| BLEED EASILY | | |
| GLAUCOMA | | |
| OTHER | | |