Premier Plastic Surgery
OF NEW ENGLAND

Family History Intake Form

Patient Name:_____ **Date of Visit:** _____

Has anyone in your family had, or been treated for any of the following conditions? If so, who?

Father: Alive or Deceased

If Deceased, cause of death: ____Natural

Other cause:_____

Age deceased: _____

Mother: Alive or Deceased

If Deceased, cause of death: ____Natural

Other cause: _____

Age Deceased:_____

Cardiac

- ☐ Heart Disease_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Angina _____
- ☐ Congestive Heart Disease_____

Vascular

- ☐ Stroke _____

Respiratory

- ☐ Anesthesia Complications_____
- ☐ Asthma _____
- ☐ Lung Cancer_____
- ☐ Respirator Disease _____
- ☐ Severe Allergies _____

Endocrine

- ☐ Diabetes _____
- ☐ Thyroid Disorder _____
- ☐ Weight Disorder _____

Gastrointestinal

- ☐ Colon Cancer _____
- ☐ Pancreatic Cancer_____

Breast

- ☐ Breast Cancer _____

Skin

- ☐ Basal /Squamous cell_____
- ☐ Melanoma _____

Genitourinary

- ☐ Kidney or Renal Disease_____
- ☐ Cervical Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Uterine Cancer _____
- ☐ Endometriosis_____
- ☐ Prostate cancer_____

Blood/Lymph/Immune

- ☐ Anemia _____
- ☐ Bleeding Disorder _____

Musculoskeletal

- ☐ Arthritis _____
- ☐ Birth Defects _____
- ☐ Osteoporosis _____

Neurological

- ☐ Alcoholism _____
- ☐ Anxiety _____
- ☐ Migraines _____
- ☐ Depression _____
- ☐ Seizures _____
- ☐ Psychiatric Care _____

Other:_____