

Name: _____

Date of Birth: _____

FamilyHistory

	Mother	Father	Brother	Sister	Other
Atherosclerosis {hardening of artery)	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Arthritis	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Asthma	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Coronary Artery Disease	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Cancer	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Cataract	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Depression	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Diabetes Mellitus	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Eczema	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Epilepsy	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Glaucoma	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Ischemic Heart Disease - (poor blood supply to heart)	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Hypertension	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Hyperlipidemia {Cholesterol}	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Macular Degeneration	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Mental Illness	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Migraine Headache	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Osteoporosis	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Renal Disease	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Stroke	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Thyroid Disease	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Other	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
Family History of Adopted	<input type="radio"/> Yes	FamilyHistoryof Unknown /unreported			<input type="radio"/> Yes