

“Each time history repeats itself the price goes up.”

– Ronald Wright

STEP ONE: YOUR FAMILY HEALTH HISTORY

How To Get Started: The easiest way to begin is by talking to your family members about their current health and health history. Use this form to assist you in gathering your family’s health history and the first step in your health planning. The more information you can gather the better; however, it is okay if you cannot answer every question, fill in as much as you can. Complete the form below or download it from our website to complete it digitally. Please note this tool focuses on the most common genetically linked conditions and the chronic illnesses that are most related to lifestyle and behavioral factors. If you do not see a condition listed that runs in your family, please record it in the ‘other’ section as it is still important to know.

An important point to consider is how closely related you are to someone in your family who has a genetically linked condition. In this step you may see the terms first-degree, second-degree and third-degree to refer to family members. These terms are defined for you below:

First degree relatives — are one step away from you. They include parents, children or siblings.

Second degree relatives — are two steps away from you. They include half-siblings, grandparents, aunts, uncles and grandchildren.

Third degree relatives — are three steps away from you. They include first cousins and great-grandparents.

**This form should not replace a health history form from your health care provider’s office but please share it with them as it gives them helpful information about conditions you may develop and may determine which tests and screenings are best for you*

A project by



Walton Wellness' Family Health History Form

Your Name: _____

Date of Birth: _____ **Sex:** _____ **Are you adopted? (Circle Y/N):** Y N

Ethnicity (check all the apply):

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

Address: _____

Best form of Contact: _____

Occupation: _____ **Highest Grade Completed** _____

Family Doctor: _____

Family Health History:

Your Birth Mother (1st degree relative):

Name: _____ **Maiden Name:** _____

Date of Birth: _____ **Sex:** _____ **Highest Grade Completed** _____

Ethnicity (check all the apply): **Was your mother adopted? (Circle Y/N):** Y N

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

(If Deceased): Age of Death: _____ **Cause of Death:** _____

Mother's health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
<i>Age Diagnosed:</i>		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N
Bone/Joint:		
Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N

Mental Health:		
Anxiety	Y	N
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:		
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N
Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Your Birth Father (1st degree relative):

Name _____

Date of Birth: _____ Sex: _____ Highest Grade Complete _____

Ethnicity (check all the apply): _____ Was your father adopted? (Circle Y/N): Y N

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Other: _____

(If Deceased): Age of Death: _____ Cause of Death: _____

Father's health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
<i>Age Diagnosed:</i>		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N
Bone/Joint:		

Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N
Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Your Mother's Biological Mother (2nd degree relative):

Name: _____

Date of Birth: _____ Sex: _____ Highest Grade Completed: _____

Ethnicity (check all the apply): Was your grandmother adopted? (Circle Y/N): Y N

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

(If Deceased): Age of Death: _____ Cause of Death: _____

Maternal Grandmother's health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
<i>Age Diagnosed:</i>		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N

Bone/Joint:		
Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N
Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Your Mother's Biological Father (2nd degree relative):

Name: _____

Date of Birth: _____ Sex: _____ Highest Grade Completed _____

Ethnicity (check all the apply): Was your grandfather adopted? (Circle Y/N): Y N

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Other: _____

(If Deceased): Age of Death: _____ Cause of Death: _____

Maternal Grandfather's health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
<i>Age Diagnosed:</i>		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N

Bone/Joint:		
Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N
Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Your Father's Biological Mother (2nd degree relative):

Name: _____

Date of Birth: _____ Sex: _____ Highest Grade Completed _____

Ethnicity (check all the apply): Was your grandmother adopted? (Circle Y/N): Y N

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

(If Deceased): Age of Death: _____ Cause of Death: _____

Paternal Grandmother's health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
<i>Age Diagnosed:</i>		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N

Bone/Joint:		
Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N
Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Your Father's Biological Father(2nd degree relative):

Name: _____

Date of Birth: _____ Sex: _____ Highest Grade Completed _____

Ethnicity (check all the apply): _____ Was your grandfather adopted? (Circle Y/N): Y N

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Other: _____

(If Deceased): Age of Death: _____ Cause of Death: _____

Paternal Grandfather's conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
<i>Age Diagnosed:</i>		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N
Bone/Joint:		

Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N
Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Please use the next three charts to record health history for any other family members with significant health conditions. This can include siblings or children (1st degree relatives) aunts and uncles (2nd degree relatives), or great-grandparents and first cousins (3rd degree relatives).

Relationship: _____

Name: _____

Date of Birth: _____ **Sex:** _____ **Highest Grade Completed:** _____

Ethnicity (check all the apply): **Was this family member adopted? (Circle Y/N):** Y N

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

(If Deceased): Age of Death: _____ **Cause of Death:** _____

Health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N

Age Diagnosed:		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
Age diagnosed:		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N
Bone/Joint:		
Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N

Alcohol Use (how often/for how long):	Y	N
Other Addiction (substance(s)/duration:	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Relationship: _____

Name: _____

Date of Birth: _____ Sex: _____ Highest Grade Completed _____

Ethnicity (check all the apply): Was this family member adopted? (Circle Y/N): Y N

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Other: _____

(If Deceased): Age of Death: _____ Cause of Death: _____

Health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
Age Diagnosed:		
High Cholesterol	Y	N

Atrial fibrillation (AFib)	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N
Bone/Joint:		
Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N

Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		

Relationship: _____

Name: _____

Date of Birth: _____ **Sex:** _____ **Highest Grade Completed** _____

Ethnicity (check all the apply): **Was this family member adopted? (Circle Y/N):** Y N

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

(If Deceased): Age of Death: _____ **Cause of Death:** _____

Health conditions (Circle Y or N for each condition)		
Weight:		
Overweight	Y	N
Type II Diabetes (adult)	Y	N
Hypothyroidism (underactive)	Y	N
Hyperthyroidism (overactive)	Y	N
Other:	Y	N
Heart:		
High Blood Pressure	Y	N
<i>Age Diagnosed:</i>		
High Cholesterol	Y	N
Atrial fibrillation (AFib)	Y	N

Heart Disease	Y	N
Heart Attack	Y	N
<i>Age diagnosed:</i>		
Cardiomyopathy	Y	N
Stroke	Y	N
Other:	Y	N
Lungs:		
Emphysema	Y	N
Asthma	Y	N
Other:	Y	N
Bone/Joint:		
Osteoarthritis (age-related)	Y	N
Rheumatoid Arthritis/RA (auto-immune)	Y	N
Osteoporosis	Y	N
Other:	Y	N
Digestive:		
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Polyps	Y	N
Colon Cancer	Y	N
Other:	Y	N
Mental Health:		
Anxiety		
Did this condition interfere with their daily function?	Y	N
Depression	Y	N
Did this condition interfere with their daily function?	Y	N
ADD/ADHD	Y	N
Autism	Y	N
Alzheimer's	Y	N
Other:	Y	N
Addictive Diseases:		
Smoking (how often/for how long):	Y	N
Alcohol Use (how often/for how long):	Y	N

Other Addiction (substance(s)/duration):	Y	N
Did any of these addictions interfere with their daily function?	Y	N
Other:		
Cancer (what kind):	Y	N
Type I Diabetes (childhood)	Y	N
Other significant health problems:		