State of Connecticut
Department of Developmental Services

Family Health History

Name:_____ **D.O.B.:**_____

Address:_____

Please indicate by checking the appropriate box if any of the person's blood relatives have been identified to have any of the following conditions.

	Father	Mother	Brother	Sister	Grandfather	Grandmother
Alcoholism						
Anemia						
Arthritis						
Asthma						
Bleeds easily						
Cancer (indicate type/ location)						
Diabetes						
Epilepsy/ Seizures						
Glaucoma						
Hayfever						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Liver Disease						
Mental Illness						
Migraine Headaches						
Osteoporosis						
Stroke						
Thyroid						
Other (describe)						

Please indicate if the person's biological parents are no longer living:

Age at death Mother_____ Father_____
Cause of death Mother_____ Father_____

Please indicate the following information regarding the person's biological siblings:

Gender of Sibling	Age of Sibling if living	Cause of death if deceased	Age at death

Other Pertinent Information:_____
_____

Completed by: _____ **Date of Completion:**_____