Family Medical History Questionnaire

Dear [Recipient's Name],

As part of our commitment to your health and well-being, we kindly ask you to complete our Family Medical History Questionnaire. This information will help us better understand your family's health background and provide personalized care.

Family Member Details

Relationship to You:

Age:

Medical Conditions:

Please List All Relevant Family Members

1. Parent - [ ]
2. Sibling - [ ]
3. Grandparent - [ ]
4. Other - [ ]

Additional Comments

Submit

Thank you for taking the time to provide us with this important information.

Sincerely,
[Your Name]
[Your Title]
[Your Institution]