Lineage Health History Form

Date: _____

To: [Healthcare Provider's Name]

Address: [Healthcare Provider's Address]

City, State, Zip: [Healthcare Provider's City, State, Zip]

Dear [Healthcare Provider's Name],

I am writing to provide you with my lineage health history as requested. Please find the information below:

Personal Information

Name: _____

Date of Birth: _____

Address: _____

Contact Number: _____

Family Medical History

Immediate Family

Mother:

- Health Conditions: _____

- Age at Death (if applicable): _____

Father:

- Health Conditions: _____

- Age at Death (if applicable): _____

Siblings

- Sibling 1: _____

- Health Conditions: _____

- Sibling 2: _____

- Health Conditions: _____

Grandparent Medical History

Maternal Grandmother: _____

- Health Conditions: _____

Maternal Grandfather: _____

- Health Conditions: _____

Paternal Grandmother: _____

- Health Conditions: _____

Paternal Grandfather: _____

- Health Conditions: _____

Please feel free to reach out if you require any additional information.

Sincerely,

[Your Name]

[Your Signature]