Patient Genealogical Health Assessment

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Dear [Patient's Name],

We are conducting a genealogical health assessment to better understand your family health history. This information can help in assessing your risks and tailoring your healthcare plan accordingly.

Family Health History

Please provide the following information about your immediate family members:

Relation	Name	Age	Health Conditions
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
Grandparents	_____	_____	_____

Additional Information

Please list any known genetic conditions or concerns in your family:

Thank you for providing this important information. It will assist us in delivering the best care possible to you and your family.

Sincerely,

[Your Healthcare Provider's Name]

[Your Healthcare Facility]