

Request for Family Medical History

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Recipient's Name]

[Recipient's Title/Position]

[Medical Institution/Practice Name]

[Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a report of our family medical history in relation to [specific medical procedure or reason]. This information is crucial for [explain reason for request, e.g., upcoming medical procedure, ongoing health monitoring].

Please include any relevant details pertaining to [specific conditions, diseases, or health concerns] that may be significant for my records.

Thank you for your attention to this matter. I appreciate your assistance in providing this important information.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]