

Family Medical History for (Member's Name): _____ Member's Social Security Number: _____

In your own words, please tell us about each family member's medical care over the past year. If additional space is needed, please feel free to copy this page as necessary. Please sign the bottom of this form before you return it to us. Thank you.

PATIENT'S NAME	LIST ALL CONDITIONS PATIENT WAS TREATED FOR	PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF THE TREATING PHYSICIAN, HOSPITAL, OR MEDICAL PROFESSION	DATE FIRST TREATED	DATE LAST TREATED

Member's Signature: _____ Date: _____