# Family Medical Background Questionnaire for Critical Illness Risk

## Personal Details

Full Name

Date of Birth

Gender

Select

## Family Medical History

| Relation | Alive/Deceased | Age (if living) | Age at death (if deceased) | Major Illnesses |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Sibling 1 | | | | |
| Sibling 2 | | | | |

List major illnesses (e.g., heart disease, cancer, diabetes, stroke, etc.)

## Specific Family Incidence of Critical Illness

Has any relative had any of the following? (Check all that apply and specify which relative)

| Critical Illness | Relative | Age at Diagnosis |
|---|---|---|
| Heart Disease | | |
| Cancer | | |
| Stroke | | |
| Diabetes | | |

| | | |
|---|---|---|
| Other (specify) | | |

## Comments or Additional Information