



**YELENA LAPIDUS MD**

Personalized Medicine for Healthy Longevity

## **FAMILY HISTORY**

Please fill in bubbles completely

<b><u>Mother:</u></b>				<i>Please fill in any that apply.</i>			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Crippling Arthritis	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Severe Allergies
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus			
<b><u>Father:</u></b>							
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Crippling Arthritis	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Severe Allergies
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus			
<b><u>Paternal Grand Mother (Fathers Side):</u></b>							
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Crippling Arthritis	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Severe Allergies
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus			
<b><u>Paternal Grand Father (Father's Side):</u></b>							
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Crippling Arthritis	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Severe Allergies
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus			

# FAMILY HISTORY

Please fill in bubbles completely

<b><i>Maternal Grand Mother (Mother's Side):</i></b>				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Chronic Lung Disease		<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Crippling Arthritis	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Severe Allergies	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus
<b><i>Maternal Grand Father (Mother's Side):</i></b>				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Chronic Lung Disease		<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Crippling Arthritis	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Severe Allergies	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus
<b><i>Siblings:</i></b>				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Chronic Lung Disease		<input type="checkbox"/> Alzheimers
<input type="checkbox"/> Crippling Arthritis	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> Severe Allergies	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lupus