**FAMILY HEALTH HISTORY**

PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blanks in those spaces that do not apply. If you require more space, please use the reverse side of this form.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CONDITION: | FATHER | MOTHER | SPOUSE | BROTHER(S) | | SISTER(S) | | CHILDREN | | |
|  | AGE: | AGE: | AGE: | AGE: | AGE: | AGE: | AGE: | AGE: | AGE: | AGE: |
| ADD/ADHD |  |  |  |  |  |  |  |  |  |  |
| ARTHRITIS |  |  |  |  |  |  |  |  |  |  |
| ASTHMA/ HAY FEVER |  |  |  |  |  |  |  |  |  |  |
| AUTISM |  |  |  |  |  |  |  |  |  |  |
| BACK TROUBLE |  |  |  |  |  |  |  |  |  |  |
| BURSITIS |  |  |  |  |  |  |  |  |  |  |
| CANCER |  |  |  |  |  |  |  |  |  |  |
| CONSTIPATION |  |  |  |  |  |  |  |  |  |  |
| DIABETES |  |  |  |  |  |  |  |  |  |  |
| DISK PROBLEMS |  |  |  |  |  |  |  |  |  |  |
| EMOTIONAL PROBLEMS |  |  |  |  |  |  |  |  |  |  |
| EMPHYSEMA |  |  |  |  |  |  |  |  |  |  |
| EPILEPSY |  |  |  |  |  |  |  |  |  |  |
| HEADACHES |  |  |  |  |  |  |  |  |  |  |
| HEART TROUBLE |  |  |  |  |  |  |  |  |  |  |
| HIGH BLOOD PRESSURE |  |  |  |  |  |  |  |  |  |  |
| INSOMNIA |  |  |  |  |  |  |  |  |  |  |
| KIDNEY TROUBLE |  |  |  |  |  |  |  |  |  |  |
| LIVER TROUBLE |  |  |  |  |  |  |  |  |  |  |
| MIGRAINES |  |  |  |  |  |  |  |  |  |  |
| MULTIPLE SCLEROSIS |  |  |  |  |  |  |  |  |  |  |
| NERVOUSNESS |  |  |  |  |  |  |  |  |  |  |
| NEURITIS |  |  |  |  |  |  |  |  |  |  |
| PINCHED NERVE |  |  |  |  |  |  |  |  |  |  |
| SCOLIOSIS |  |  |  |  |  |  |  |  |  |  |
| SINUS TROUBLE |  |  |  |  |  |  |  |  |  |  |
| SYPHILLIS |  |  |  |  |  |  |  |  |  |  |
| OTHER: |  |  |  |  |  |  |  |  |  |  |

If any of the above family members are deceased, please list their age at and cause of death:\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_