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:___________

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