

# FAMILY HEALTH HISTORY

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Please review the below-listed conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

Condition	Father	Mother	Spouse	Brothers		Sisters		Children	
	Age:	Age:	Age:	Age:	Age:	Age:	Age:	Age:	Age:
Arthritis									
Asthma - Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

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

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