

FAMILY HEALTH HISTORY

Patient _____ Date _____

Please review the below listed diseases and conditions 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 blank those spaces that do not apply. If you require more space, 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 ____
Arthritis									
Asthma- Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problems									
Emotional Problems									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Migraine									
Nervousness									
Neuritis									
Pinched Nerves									
Scoliosis									
Sinus Trouble									
Stomach Troubles									
Other:									

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