

FAMILY HEALTH HISTORY

Patient _____

Date _____

Please review the below listed disease 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 Age__ | Mother Age__ | Spouse Age__ | Brothers Age__ | Brothers Age__ | Sisters Age__ | Sisters Age__ | Children Age__ | Children Age__ | Children 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 | | | | | | | | | | |
| Liver Trouble | | | | | | | | | | |
| Migraine | | | | | | | | | | |
| Nervousness | | | | | | | | | | |
| Neuritis | | | | | | | | | | |
| Pinched Nerves | | | | | | | | | | |
| Scoliosis | | | | | | | | | | |
| Sinus Trouble | | | | | | | | | | |
| Stomach Trouble | | | | | | | | | | |
| Other: | | | | | | | | | | |
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If any of the above family members are deceased, please list their age at death and cause. _____