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, us the reverse side of this form.

CONDITION	FATHER AGE ___	MOTHER AGE ___	SPOUSE AGE___	BROTHER(S) AGE___ AGE___		SISTER(S) AGE___ AGE___		CHILDREN 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										
Liver Trouble										
Migraines										
Nervousness										
Neuritis										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

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

_____

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