FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Name _____ Date _____

Please review the below-listed diseases and 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 area, as some hereditary conditions are affected by similar climate.

Condition	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	BROTHER(s) Age ( ) Age ( )		SISTER(s) Age ( ) Age ( )		CHILDREN Age ( ) Age ( ) Age ( )		
Arthritis										
Asthma / Hay Fever										
Back / Neck trouble										
Bursitis										
Cancer (type or area)										
Constipation / Diarrhea / Digestive Complaints										
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 age at death and cause.

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If any other blood relatives have or had a specific medical condition, please list.

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