## **FAMILY HEALTH HISTORY**

Patient Name	Date
1 aticit Name	Date

Please review the below listed symptoms and conditions and indicate those that are <u>current</u> health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a <u>past</u> problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	Father	Mother	Spouse	<b>Brother</b> (s)		Sister(s)		Children		
	Age	Age	Age	Age	Age	Age	Age	Age	_Age	Age
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										