**FAMILY HEALTH HISTORY**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please review the below listed symptoms 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.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Father**Age\_\_\_\_ | **Mother**Age\_\_\_\_ | **Spouse**Age\_\_\_\_ | **Brother**(s)Age\_\_\_\_ Age\_\_\_\_ | **Sister**(s)Age\_\_\_\_ Age\_\_\_\_ | **Children**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: |  |  |  |  |  |  |  |  |  |  |