## **FAMILY HEALTH HISTORY**

Patient Name	Date	
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Please review the below listed symptoms and conditions and indicate those that are  $\underline{\text{current}}$  health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a  $\underline{\text{past}}$  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		Age	Children AgeAge	
First Name										
Allergies										-
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Frequent Colds/Flu										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble					W					
Sleeping Problems										
Other:										