FAMILY HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

Please review the diseases and conditions listed below and indicate those that are health problems of a family member and who the family member is whether it is your Mother, Father, Siblings, Spouse or Children.

CONDITION	**YES/NO**	**RELATION**	**CONDTION**	**YES/NO**	**RELATION**
ADHA			EMOTION ISSUES		
ALLERGIES			EMPHYSEMA		
ARTHRITIS			EPILEPSY		
ASTHMA			HEADACHES		
AUTISM			MIGRAINES		
BACK TROUBLE			HEARTBURN		
BED WETTING			HEART TROUBLE		
BURSITIS			HIGH BLOOD PRES.		
CANCER			IBS		
CHEST PAIN			INDIGESTION		
COLIC			INFERTILITY		
COLITIS			INSOMNIA		
CONSTIPATION			KIDNEY TROUBLE		
CROHN DISEASE			NECK PAIN		
DEPRESSION			NERVOUSNESS		
DIABETES			NEURITIS		
DIARRHEA			PINCHED NERVE		
DISC PROBLEMS			SCOLIOSIS		
DOWN SYNDROME			SINUS TROUBLE		
EAR INFECTIONS			OTHER		

ADDITIONAL COMMENTS: _____

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