FAMILY HEALTH HISTORY

NAME:____Date:___________

Please review the below listed conditions and indicate those that apply as follows:

~ Mark "**C**" in his/her column if it is a CURRENT health problem, or

~ mark "**P**" if this is a PAST health problem, or leave blank if it does not apply.

	Self	Father	Mother	Spouse	Children			Sisters			Brothers		
Current Ages :													
CONDITION:													
Alzheimer's													
Arthritis													
Asthma-Hay Fever													
Back Trouble													
Bursitis													
Cancer													
Constipation													
Diabetes													
Disc Problem													
Emotional Problems													
Emphysema													
Epilepsy													
Headaches													
Heart Trouble													
High Blood Pressure													
Insomnia													
Kidney Trouble													
Liver Trouble													
Migraines													
Nervous/Anxiety													
Neuritis													
Osteoporosis													
Parkinson's													
Pinched Nerve													
Sinus Trouble													
Stomach Trouble													
Thyroid Problems													
Other:													

If any of the above family members are deceased, please list their age and cause of death:

____