

## Health History of Family Members

The reason for this form is to assist the doctor by providing past health history information for his review

| Condition           | Self | Father | Mother | Spouse | Brothers | Sisters | Children |
|---------------------|------|--------|--------|--------|----------|---------|----------|
| Arthritis           |      |        |        |        |          |         |          |
| Asthma              |      |        |        |        |          |         |          |
| Back Trouble        |      |        |        |        |          |         |          |
| Cancer              |      |        |        |        |          |         |          |
| Constipation        |      |        |        |        |          |         |          |
| Diabetes            |      |        |        |        |          |         |          |
| Disc Problems       |      |        |        |        |          |         |          |
| Drinker             |      |        |        |        |          |         |          |
| Drug Addiction      |      |        |        |        |          |         |          |
| Emphysema           |      |        |        |        |          |         |          |
| Epilepsy            |      |        |        |        |          |         |          |
| Headaches           |      |        |        |        |          |         |          |
| Heart Trouble       |      |        |        |        |          |         |          |
| High Blood Pressure |      |        |        |        |          |         |          |
| Kidney Trouble      |      |        |        |        |          |         |          |
| Migraine            |      |        |        |        |          |         |          |
| Nervousness         |      |        |        |        |          |         |          |
| Neuritis            |      |        |        |        |          |         |          |
| Neuralgia           |      |        |        |        |          |         |          |
| Pinched Nerve       |      |        |        |        |          |         |          |
| Sinus Trouble       |      |        |        |        |          |         |          |
| Smoker              |      |        |        |        |          |         |          |
| Sports Activities   |      |        |        |        |          |         |          |
| Stomach Trouble     |      |        |        |        |          |         |          |
| Deceased            |      |        |        |        |          |         |          |

Name: \_\_\_\_\_

Date: \_\_\_\_\_