Family Health History

Name _____ Date _____

Please indicate a C under his or her coloumn for CURRENT lifestyles or health conditions or a P for past lifestyles or health conditions. Leave blank if it does not apply. If you require more space please use the back of this form.

	Father	Mother	Spouse	Brothers		Sisters		Children			
Lifestyle	Age	Age	Age	Age	Age	Age	Age	Age	Age	Age	Age
Ate peanut products											
Ate red meat											
Ate sweets/cookies											
Ate/Drank dairy											
Drank alcohol											
Drank soda											
On medicatations											
Smoked cigarettes											
Conditions											
Arthritis											
Asthma											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Diabetes											
Disc Problems											
Emotional Promblems											
Emphysema											
Epilepsy											
Headaches											
Heart Trouble											
High Blood Presssure											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraines											
Nervousness											
Neuritis											
Pinched Nerve											
Scolisos											
Sinus Trouble											
Stomach Trouble											
Other:											