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Sarasota, FL 34232

Family Health History

Patient _____Date_____

Please review the below-listed diseases and conditions and indicate those that are current health problems of yours or a family member. Leave blank thoses spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

	Yourself	Father	Mother	Spouse	Brother	Sister	Child	Child
CONDITION	Age	Age	Age	Age	Age	Age	Age	Age
Allergies								
Arthritis								
Asthma								
Back Trouble								
Bursitis								
Cancer								
Carpal Tunnel								
Constipation								
Diabetes								
Disc Problems								
Ear Infection								
Emphysema								
Epilepsy								
Headaches								
Heart Disease								
High Blood Pressure								
Impotency								
Insomnia								
Joint Pain								
Kidney Trouble								
Liver Trouble								
Mental Disorders								
Migraines								
Neck Pain								
Numbness hands/feet								
Pinched Nerve								
Sciatica								
Spinal Curvature								
Sinus Trouble								
TMJ								
Urinary Tract								
Other:								