Allegheny Health & Rehabilitation Center

FAMILY HEALTH HISTORY FORM

Patient Name:_____ Date:_____

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member.

C = Current Problem P = Past Problem D = Deceased

Condition	Father	Mother	Spouse	Brothers		Sisters		Children		
	Age	Age	Age	Age	Age	Age	Age	Age	Age	Age
Arthritis										
Asthma										
Back Problems										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emotional Problems										
Emphysema										
Epilepsy										
Fibromyalgia										
Headaches										
Heart Problems										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Problems										
Migraines										
Neuritis										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other										