FAMILY HEALTH HISTORY

If you or any member of your family have experienced any of the following please check it off in the appropriate space

Condition	SELF	SPOUSE	MOTHER	FATHER	CHILD	CHILD
HEADACHES						
SINUS TROUBLE						
ALLERGIES						
EYE TROUBLES						
EARACHES						
HEARING DYSFUNCTION						
SKIN DISORDERS						
THROAT PROBLEMS						
NECK OR SHOULDER PAIN OR PROBLEMS						
TONSILLITIS						
FREQUENT COLDS						
BURSITIS						
THYROID DISORDERS						
ASTHMA						
BREATHING PROBLEMS						
PAIN IN ARMS OR HANDS						
HEART DYSFUNCTION						
CHEST PAIN						
SHINGLES						
LIVER PROBLEMS						
ANEMIA						
STOMACH DISORDERS						
DIABETES						
DIGESTIVE PROBLEMS						
COLITIS						
HERNIA						
APPENDICITIS						
MENSTRUAL DISORDER						
IMPOTENCY						
URINATION PROBLEMS						
BACKACHES						
WEAKNESS / CRAMPS IN THE LEGS						
HEMORRHOIDS						