

Family Personal History

Clients Name _____

Do you have any of the following?	Circle one		Date of onset	Current Status
Cancer	Yes	No		
Diabetes	Yes	No		
Hypoglycemia	Yes	No		
Hypertension	Yes	No		
Heart Disease	Yes	No		
Angina or chest pain	Yes	No		
Shortness of breath	Yes	No		
Stroke	Yes	No		
Kidney Disease/Stones	Yes	No		
Urinary tract Infection	Yes	No		
Allergies	Yes	No		
Asthma/Hay fever	Yes	No		
Rheumatic/Scarlet fever	Yes	No		
Cirrhosis/Liver disease	Yes	No		
Polio	Yes	No		
Chronic Bronchitis	Yes	No		
Pneumonia	Yes	No		
Emphysema	Yes	No		
Migraine headaches	Yes	No		
Anemia	Yes	No		
Ulcers/stomach problems	Yes	No		
Arthritis/Gout	Yes	No		
Hemophilia/Slow healing	Yes	No		
Guillain – Barre syndrome	Yes	No		
Epilepsy	Yes	No		
Thyroid problems	Yes	No		
Multiple sclerosis	Yes	No		
Tuberculosis	Yes	No		
Fibromyalgia	Yes	No		
Other (please describe)				
If female, Are you pregnant?	Yes	No		If yes how many months?

