

FAMILY MEDICAL HISTORY

The Hills Medical Group
THE CENTER FOR HEALTH AND HEALING

PATIENT _____

CONDITION Check all that apply	RELATIVE/S Beside each condition print anyone in the family who has/had the disorder. (i.e. Mother/ Father/ Sibling/s /Mother's mother/ Mother's Father/ Father's mother/ Father' father/ 1st cousin/etc.)
ADD/ADHD	
Alcohol Abuse / Drug Abuse	
Allergy to Milk	
Allergy to Wheat	
Alzheimer's Disease	
Anemia	
Asperger's Syndrome	
Asthma	
Autistic Spectrum Disorder	
Auto-immune Problems	
Bipolar Disorder	
Breathing Problems	
Bronchitis	
Cancer--please specify type	
Celiac Disease	
Cough	
Crohn's Disease	
Depression	
Diabetes	
Ear Infections	
Eating Disorder	
Eczema	

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	Fungal Infections	
	Gluten Intolerance	
	Headaches / Migraines	
	Heart Disease	
	Hives	
	Insomnia	
	Irritable / Inflammatory Bowels	
	Learning Disability	
	Light Sensitivity	
	Manic Depressive	
	Mood Swings	
	Night Vision Problems	
	Obsessive Compulsive Disorder	
	Panic Attacks	
	Psoriasis	
	Reflux / Heart Burn	
	Schizophrenia	
	Seasonal Allergies	
	Sinusitis	
	Speech Delay	
	Stomach Problems	
	Stroke	
	Surgeries--please specify	
	Thyroid Problems	