Queen Anne Naturopathic Center

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Patient Name:_____ **Date:** _____

FAMILY HISTORY- ILLNESSES: (Parents, Grandparents, Brothers & Sisters, Aunts & Uncles - blood rel.)

DISEASE:	WHO: (Mother's side)	COMMENTS:	WHO: (Dad's side)	COMMENTS:
Auto-Immune				
Lupus, other				
Blood problems				
Anemia				
Blood disorders				
Cardiovascular				
Angina (Chest pains)				
Heart attack				
High blood pressure				
High cholesterol				
Stroke				
Chemical dependency				
Alcoholism, other				
Chronic Infections				
Digestive				
Stomach Ulcers				
Eating disorder				
Anorexia/Bulemia/Overeating				
Endocrine				
Diabetes				
Thyroid (hyper/hypo)				
Obesity				
Eye problems				
Cataracts/Glaucoma/blindness				
Intestinal problems				
IBS, Ulc. Colitis, Chron's				
Kidney disease				
Kidney stones				
Kidney failure/dialysis				
Liver/Gallbladder disease				
Hepatitis/Cirrhosis				
Gallstones				
Mental/Psychological				
Anxiety				
Depression/Bipolar/Suicidal				
Memory loss/Alzheimers				
Neurological				
Headaches/Migraines				
Epilepsy/Convulsions				
MS/ALS/paralysis				
Reproductive - Male				
Urination/Prostate problems				
Reproductive - Female				
Hysterectomy, Other				
Respiratory/Breathing				
Allergies				
Asthma				
Emphysema				
Skeletal				
Arthritis/Gout				
Osteoporosis/Osteopenia				
Skin disorders				
Eczema/Psoriasis				
Cancer *(not otherwise noted)*				
type:				