

Family Health History for \_\_\_\_\_ date of birth: \_\_\_\_\_ completed by: \_\_\_\_\_  
 child's name

Please check the appropriate box and list the relative. Include child's mother, father, siblings, grandparents, aunts, uncles, and first cousins; only relatives related to child by blood.

	YES	Who?		YES	Who?
allergies.....	<input type="checkbox"/>	_____	heart attack/stroke/bypass (before age 50)	<input type="checkbox"/>	_____
drug allergies .....	<input type="checkbox"/>	_____	high blood pressure (before age 50).....	<input type="checkbox"/>	_____
asthma.....	<input type="checkbox"/>	_____	high cholesterol .....	<input type="checkbox"/>	_____
eczema.....	<input type="checkbox"/>	_____	obesity/overweight .....	<input type="checkbox"/>	_____
birth defects .....	<input type="checkbox"/>	_____	kidney disease .....	<input type="checkbox"/>	_____
(cleft lip, heart defect...)			organ transplant .....	<input type="checkbox"/>	_____
bleeding/clotting disorder .....	<input type="checkbox"/>	_____	migraine headache.....	<input type="checkbox"/>	_____
(hemophillia, vonWillebrand, factor V leiden deficiency...)			ADHD or ADD .....	<input type="checkbox"/>	_____
eye/vision problem .....	<input type="checkbox"/>	_____	learning disability .....	<input type="checkbox"/>	_____
hearing loss .....	<input type="checkbox"/>	_____	mental retardation .....	<input type="checkbox"/>	_____
frequent ear infections/tubes .....	<input type="checkbox"/>	_____	depression, anxiety, bipolar.....	<input type="checkbox"/>	_____
diabetes (before age 50).....	<input type="checkbox"/>	_____	other mental illness .....	<input type="checkbox"/>	_____
thyroid/other endocrine disease .....	<input type="checkbox"/>	_____	alcohol, drug problem/addiction .....	<input type="checkbox"/>	_____
gastrointestinal disease .....	<input type="checkbox"/>	_____	suicide .....	<input type="checkbox"/>	_____
(crohn's, ulcerative colitis, IBS...)			scoliosis, cong/dev hip dysplasia .....	<input type="checkbox"/>	_____
genetic condition .....	<input type="checkbox"/>	_____	tuberculosis .....	<input type="checkbox"/>	_____
(sickle cell, cystic fibrosis...)			immune disorder, HIV or AIDS.....	<input type="checkbox"/>	_____
hepatitis B or C.....	<input type="checkbox"/>	_____	rheumatoid disease .....	<input type="checkbox"/>	_____
cancer .....	<input type="checkbox"/>	_____	(lupus, Raynaud's, rheumatoid arthritis...)		
death before age 70 .....	<input type="checkbox"/>	_____	other (specify: _____)	<input type="checkbox"/>	_____

**DATE**

**FAMILY HEALTH HISTORY**

**MD Signature** \_\_\_\_\_