FAMILY HISTORY

Patient's Name_____________________________ Date of Birth_________________________
Completed by____________________________ Relation_______________ Today's Date__________

If condition is present in the family, check the box **and** list to the right of the box, the relative's relationship to child as: Mother (M), Father (F), child's Brother (B), or Sister(S), Maternal Aunt/Mom's sister (M Aunt), Paternal Aunt/Dad's sister (P Aunt), Maternal Grandmother/Mom's mother (MGM), Paternal Grandmother/Dad's Mother (PGM), Maternal Grandfather/Mom's father (MGF), paternal uncle/Dad's brother (P Uncle), etc. Only list family related by blood.
List here names of siblings with the SAME family history:____
If unknown, mark here: maternal family history unknown ☐ paternal family history unknown ☐

if Yes check ☐ and list Who?	if Yes check ☐ and list Who?
Allergies to______________ ☐ ______________	Hepatitis B ☐ or C ☐____________________
Drug Allergy to ______________ ☐ ______________	Heart disease (specify) _____________ ☐ ___________
Alcohol problem ☐ Drug Problem ☐_____________	Heart attack (age at heart attack ____) ☐ _____________
Asthma ☐ ____________________________	High Blood Pressure ☐ ________ High Cholesterol ☐ _____
ADD or ADHD ☐ ________________________	Hip dysplasia (congenital/developmental) ☐ ___________
Anorexia/Bulimia ☐ ____________________	Kidney Disease (specify) ☐ Kidney stone ☐_________
Autism/Aspergers ☐ ____________________	Learning disability ☐ ___________________________
Birth Defect specify:___________ ☐ ____________	Mental Retardation/Cognitive Impairment ☐ ____________
Blood Disorder (specify) ☐________________ Factor V Leiden Deficiency ☐ _______________ Hemophilia ☐ ___________________________ Von Willebrand's ☐ _______________________	Mental Health Condition ☐ __________________ Anxiety ☐ ____________ Other ☐______________ Bipolar ☐_____________ Schizophrenia ☐________ Depression ☐__________ Suicide ☐ ___________
Cancer (what kind?_____________) ☐ _____________	Migraine Headaches ☐ ___________________
Crohn's Disease ☐ Ulcerative Colitis ☐ _________	Rheumatoid Arthritis ☐ Lupus ☐ other ☐ ___________
Cystic Fibrosis ☐ ______________________	Scoliosis ☐ ___________________________
Death before age 70 ☐ cause?_______ who?_________	Seizure Disorder ☐___________________________
Diabetes: Type 1 ☐ Type 2 ☐______________	Sickle Cell Disease ☐ Trait ☐________________
Eczema ☐ ___________________________	Stroke (age at stroke ____) ☐ _____________

If the answer to all of the above is NO check here ☐
List other conditions not noted above or details:
____
____
____
____

FAMILY HISTORY

Patient's Name_____________________________ Date of Birth_________________________

Completed by___________________________ Relation_______________ Today's Date__________

If condition is present in the family, check the box **and** list to the right of the box, the relative's relationship to child as: Mother (M), Father (F), child's Brother (B), or Sister(S), Maternal Aunt/Mom's sister (M Aunt), Paternal Aunt/Dad's sister (P Aunt), Maternal Grandmother/Mom's mother (MGM), Paternal Grandmother/Dad's Mother (PGM), Maternal Grandfather/Mom's father (MGF), paternal uncle/Dad's brother (P Uncle), etc. Only list family related by blood.
List here names of siblings with the SAME family history:____

If unknown, mark here: maternal family history unknown ☐ paternal family history unknown ☐

if Yes check ☐ and list Who?	if Yes check ☐ and list Who?
Allergies to______________ ☐ ______________	Hepatitis B ☐ or C ☐ _____________________
Eye/vision problem specify___________ ☐ __________	Thyroid disease ☐ hyper ☐ hypo ☐ __________
Hemochromatosis ☐ ____________________	Tuberculosis ☐ Immune disorder ☐ HIV/AIDS ☐ ______

If the answer to all of the above is NO check here ☐
List other conditions not noted above or details:
____