FAMILY HISTORY

Name of Patient: _____ DOB:_____

Address:_____ Person Completing Form:_____

Please answer the following questions so we may update **your child's medical record**. If the answer is no please indicate that by checking that box. If you answer **yes** please explain your answer in the space provided.

Please complete the following Family History. The relationship should be **YOUR CHILD'S**

M= Mother **F= Father** **S= Sibling (Child's Brother/Sister)**
PGM= Grandmother(Dad's mom) **PGF= Grandfather (Dad's dad)**
MGM=Grandmother(Mom's mom) **MGF= Grandfather (Mom's dad)**

FAMILY HISTORY	NO	YES	RELATION SHIP	EXPLAIN
Allergies (seasonal, rhinitis, hayfever,asthma)				
Birth Defects (Explain)				
Blood (clots, bleeding problems, anemia)				
Cancer				
Cardiovascular (early heart disease, cardiac death, stroke, hypertension, high cholesterol)				
Endocrinology (diabetes, thyroid, reproductive)				
ENT (hearing loss, recurrent OM, T&A)				
Eyes (lazy eye, eye surgery, blindness)				
Gastrointestinal (constipation, crohns, colitis, celiac disease,GERD)				
GYN (endometriosis, infertility, PCOS)				
Immunologic (immune deficiency)				
Learning (learning disability, ADHD,IEP in school, graduation				
Neurologic (epilepsy, seizures, migraines, MS				
Orthopaedic (hip dysplasia, scoliosis, arthritis, osteoporosis				
Psychiatric(mental health problems, depression, anxiety, bipolar				
Pulmonary (asthma, CF, emphysema, COPD				
Skin (psoriasis, eczema, nevi, melanoma				
Urology (kidney problems, enuresis, VUR)				
Abuse (Explain)				
Addictions (Drugs and Alcohol)				
Other:				

FOR OFFICE USE ONLY

Form Completed : ☐ Parent ☐ Staff ☐ Reviewed ☐ OK TO IMPORT AND SCAN