FAMILY HISTORY FORM **DATE _____________**
PEDIATRIC HEALTHCARE ASSOCIATES

Patient's Name ___________________________ Nickname ______________ Date of Birth __________
Other children with same parents: ____

	Date of Birth	Height	Illness/Medical Problems
Father of child			
Mother of child			

	Illness/Medical Problem	Age Died	Cause
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Does anyone in your family have any of the following diseases? If so, state the relationship to the child.

	Yes	No	Relationship
ADHD			
Alcoholism/Drug Use			
Allergies			
Asthma			
Autism			
Birth Defects/Genetic Problems			
Bleeding Problems			
Blood Clots			
Cancer & type			
Congenital Cataract			
Celiac Disease			
Developmental Delays/Learning Disabilities			
Diabetes, type 1 or 2			
Eating Disorders			
Eczema			
Epilepsy (seizures)			
Food Allergy			
Gastrointestinal Disease (colitis, Crohn's)			
Glaucoma			

	Yes	No	Relationship
Hearing Loss			
Heart Disease			
Hemochromatosis			
High Cholesterol			
Hypertension (high blood pressure)			
Immune Disorders			
Infertility/PCOS			
Lazy Eye			
Mental Illness (depression, bipolar, anxiety)			
Migraines			
Overweight/Obesity			
Renal Disorder (kidney)			
Retinoblastoma			
Rheumatologic Disorder			
School Problems			
Scoliosis			
Sickle Cell/Thalassemia			
Smoking			
Thyroid Disease			

Are there any other medical problems that run in your family? ___________________________________

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