FAMILY HISTORY FORM

Family Last Name _____

Child's Legal Name:	Birth Date:	Child's Legal Name:	Birth Date:
1._____	_____	3._____	_____
2._____	_____	4._____	_____

Please answer the following in regards to your child's/children's family history.
Fill out a separate form for children who are adopted or have a different biological parent.

Immediate family member has or has had the following illness/condition:

				Siblings		***Paternal***		***Maternal***	
ADD/ADHD	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Allergies (food)_____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Allergies (other) _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Anesthesia Reactions	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Anxiety	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Asthma	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Autism / Aspergers	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Bleeding Disorders (Hemophilia)	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Cancer - Breast	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Cancer - Leukemia	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Cancer - Other _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Congenital Heart Disease	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Depression	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Diabetes	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Drug/Substance Abuse	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Eating Disorder (type) _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Factor V Leiden Deficiency	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Heart Attack	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
High Blood Pressure	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
High Cholesterol	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Kidney Stones	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Overweight	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Rheumatoid Arthritis	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Seizures/Epilepsy	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Stroke/Cerebrovascular Accident	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Sudden Cardiac Death	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Sudden Infant Death Syndrome (SIDS)	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Thyroid Disease	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Ureteral/Kidney Reflux	YES / NO	Father	Mother	B	S	GF	GM	GF	GM
Other _____	YES / NO	Father	Mother	B	S	GF	GM	GF	GM

Parent Signature _____ **Date** _____

*We will ask you to update this information at your child's yearly wellness check-ups.

***B = Brother S = Sister GF = Grandfather GM = Grandmother**

Updated: 09/01/11