FAMILY HISTORY QUESTIONNAIRE

PATIENT INFORMATION:
Date: _______________ (use back of sheet for additional children)
Person Filling out this form: ______________________ Relationship to child: _____________________

Child #1: _____________________________________ M F DOB___________________________
Child #2: _____________________________________ M F DOB___________________________
Child #3: _____________________________________ M F DOB___________________________
Child #4: _____________________________________ M F DOB___________________________

FAMILY HISTORY: PLEASE CHECK IF CHILD'S BIOLOGICAL RELATIVES HAVE ANY OF THESE CONDITIONS. USE THE BOTTOM OF THIS FORM IF EXTRA SPACE IS NEEDED.

	Y	N	Who was affected?	Explain
1. Allergies (Asthma, Eczema, Hay Fever)				
2. Blood disorders (Bleeding, Clotting, Sickle Cell, Anemia)				
3. Bone/ Joint/ Rheumatic disorders				
4. Cancer				
5. High Cholesterol				
6. Diabetes				
7. Eye problems (blindness, lazy eye, crossing eyes)				
8. Ear problems (hearing impairment or hearing aid)				
9. Gastrointestinal Disorders (Celiac, Crohns, Ulcerative Colitis, GERD)				
10. Genetic disorders or Birth Defects (Cystic Fibrosis, Downs syndrome, Cleft Lip, Club Foot, Hip Dysplasia)				
11. Heart disease (Heart Attacks, arrhythmia)				
12. Hypertension/ high blood pressure				
13. Infectious diseases or problems with immune system (HIV, Tb, Immunodeficiency)				
14. Kidney problems				
15. Nervous system disorders (migraines, seizures, epilepsy)				
16. Obesity				
17. Psychiatric conditions (Depression, Anxiety, ADHD)				
18. Thyroid problems				
19. Alcoholism or Drug dependence				
20. Regular Smoker				
21. Other				

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Reviewed by:_________________