

FAMILY MEDICAL HISTORY

Patient Name _____ Date of Birth _____ Date _____ Account # _____

There are some medical conditions or illnesses that can be passed on to family members. To treat your child, we need to be aware of any of the following conditions.

*Family members include child's parents and siblings, Mother's parents and siblings, and Father's parents and siblings.

If you have other children with the same Family Medical History, please include their names on the bottom of this form.

MEDICAL CONDITION	Patient's Mom	Patient's Dad	Patient's Siblings	Patient's Grandparents	Patient's Aunts and Uncles	Other	Reviewed
ADD/ADHD							
Alcoholism							
Allergies							
Lazy Eye (Amblyopia)							
Asthma							
Bipolar							
Blood Clots or Clotting Disorders							
Cancers							
Specify type of cancer							
Celiac Disease							
Cystic Fibrosis							
Stroke							
Drug Addiction							
Born with Heart Disease							
Depression							
Diabetes-Type 1 (juvenile)							
Diabetes- Type 2 (adult)							
Eating Disorder							
Glaucoma							
Hearing Loss (under 60 yrs of age)							
Heart Disease at less than age 50							
High Cholesterol							
High Blood Pressure							
Hyperthyroid (overactive)							
Hypothyroid (low)							
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)							
Kidney Disease							
Learning Disabilities (Math, Reading)							
Lupus							
Migraines							
Multiple Sclerosis							
Neurologic Diseases							
Specify type							
Newborn with dislocated hip							
Rheumatoid Arthritis							
Schizophrenia							
Seizure Disorder							
Sickle Cell Anemia							
Scoliosis							
Thalassemia							
Unexplained Sudden Death							
Other conditions that run in the family							

Siblings Names _____
