

Patient's Name:

Date:

FAMILY HISTORY FORM

On the following pages, please fill out as much information about each family member as possible. When listing any illnesses/diseases/conditions, please pay specific attention to the following:

Obesity	Seizure problems
High blood pressure	Recurrent fainting
High cholesterol	Learning disorders (ADHD, dyslexia)
Diabetes (type 1 or type 2)	Depression or anxiety
Heart attacks (please list age of first attack)	Bipolar disease (or schizophrenia)
Marfan's syndrome	Drug or alcohol issues
Other cardiac disease (rhythm disorders, murmurs, cardiomyopathy, etc. . .)	Smokers
Cysts on kidneys	Deafness (under age 40)
Other kidney disease	Infants /children with hip problems
Blood clots (including pulmonary embolism or other clotting disorders)	Blindness
Bleeding disorders (including Von Willebrand's)	Asthma
Anemia (or thalesemia traits)	Recurrent pneumonias or recurrent bronchitis
History of having spleen removed	Allergies (seasonal or food)
Sudden Infant Death syndrome (SIDS)	Thyroid disease (hypothyroid or hyperthyroid)
Auto accident/drowning deaths	Skin cancer (melanoma, basal cell)
Other unexplained deaths	Colon cancer under age 50
Tuberous sclerosis/neurofibromatosis	Kidney cancer under age 50
	Eye cancer (or eye removed)
	Other cancers

Please note: when completing this form, all relationships are from the child's perspective. "Father" refers to the patient's father (and not yours!)

Father	
Mother	
Father's father (paternal grandfather)	
Father's mother (paternal grandmother)	
Mother's father (maternal grandfather)	
Mother's mother (maternal grandmother)	
Mother's brothers (maternal uncles)	
Mother's sisters (maternal aunts)	
Father's brothers (paternal uncles)	
Father's sisters (paternal aunts)	
Patient's siblings	

<p>Has your child had any surgeries?</p> <p>If yes, please list type of surgery, who the surgeon was and dates of surgery:</p>	
<p>Has your child had any hospitalizations?</p> <p>If yes, please list and dates:</p>	
<p>Religion:</p>	
<p>Parent's Marital status</p>	
<p>Dad's Occupation:</p>	
<p>Mom's Occupation:</p>	

Please check off the answer that applies:		
What type of water do you have?	<input type="checkbox"/> Private well	<input type="checkbox"/> Municipal (town, city)
Do you have guns in your house?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you have a pool at home?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Any smokers living in the house?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you have a fire extinguisher in your house?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you have Carbon Monoxide Detector?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you live in a house or apartment?	<input type="checkbox"/> House	<input type="checkbox"/> Apartment
Type of heat:	<input type="checkbox"/> Oil	<input type="checkbox"/> Gas <input type="checkbox"/> Electric
Do you have pets?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, what type?