Family History

Patient Name: _____ Date of Birth (DOB): ____ / ____ / _____

Directions:
If you answer yes to any of the following questions, please provide more details under "comments"

Have any biological family members had...?	Child being seen	Sibling(s)	Biological Father	Biological Mother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other relatives (list)	Comments
Childhood hearing loss										
Nasal allergies/ hay fever										
Asthma										
Food Allergies										
Cystic Fibrosis										
Tuberculosis/ positive PPD										
Stroke (before 55 years old)										
Heart disease (before 55 years old)										
High cholesterol/takes cholesterol medication										
Anemia										
Bleeding disorder/hemophilia										
Dental decay										
Cancer (before 55 years old)										
Liver disease										
Kidney disease										
Diabetes (before 55 years old)										
Bed wetting (after 10 years old)										
Obesity										
Epilepsy/convulsions/seizures										
Alcohol abuse										
Drug abuse										
Tobacco abuse										
ADHD										
Anxiety										
Depression										
Mental health problems										
Autism										
Developmental disability										
Birth defects/chromosomal abnormalities										
Immune problems, HIV, or AIDS										
Migraine headaches										
Lazy eye										
Vision problems										
Hip dysplasia										
Hip problems										
Any other significant problem										