FAMILY MEDICAL HISTORY QUESTIONNAIRE

 PATIENT INFORMATION

Today's Date: _________________

Name of Person Completing Form:___________________________ **Relationship to Child**:__________________________

Child #1:______________________________ DOB:____________ Medical Problems:____

Child #2:______________________________ DOB:____________ Medical Problems:____

Child #3:______________________________ DOB:____________ Medical Problems:____

Child #4:______________________________ DOB:____________ Medical Problems:____

Child #5:______________________________ DOB:____________ Medical Problems:____

 FAMILY HISTORY

PLEASE CHECK THE BOXES OF RELATIVES WHO HAVE HAD ANY OF THE FOLLOWING PROBLEMS

Medical Condition	**Patient's Father**	**Patient's Mother**	**Father's Relative** (Please Specify Relationship to Patient)	**Mother's Relative** (Please Specify Relationship to Patient)
Allergies				
Asthma				
Attention Deficit Disorder/Hyperactivity				
Babies Born With Congenital Problems				
Bleeding Disorders				
Bowel Diseases				
Cancer				
Children Who Require Eye Patches or Glasses Before Age 5				
Deafness				
Depression/Mental Illness				
Diabetes in Children				
Diabetes in Adults Requiring Insulin				
Drug Dependency/Alcoholism				
Heart Attack or Stroke Prior to Age 55				
High Blood Pressure				
High Cholesterol Level (Above 240)				
Hip Dislocation (limp)				
Kidney Problems				
Learning Problems				
Seizures (Epilepsy)				
Sudden Unexplained Death in Young Adult or Teen				
Thyroid Problems				

FOR OFFICE USE ONLY: Scanned & Linked by (Initials): ________ Date: ____________