# FAMILY MEDICAL HISTORY
## HOSPITAL DRIVE PEDIATRICS

Patient's Name _____ DOB _____
Mother's Name _____ Age _____
Father's Name _____ Age _____
Sibling(s) of patient (Name, sex, date of birth) _____
_____

1. Have any children in the immediate or extended family died? ☐No ☐Yes
   Age and cause of death_____
2. Are the parents of this child related to each other by blood? ☐No ☐Yes
3. Is the child adopted? ☐No ☐Yes
   List biological relatives known to you _____
4. Donor ☐egg ☐sperm?

*Do any of the child's relatives (siblings, cousins, parents, aunts, uncles, grandparents) have a health problem?*

| Condition or Organ System | No | Yes | Relationship to Patient (specify if donor or adopted) |
|---|---|---|---|
| Genetic syndrome (Down, etc) | ☐ | ☐ | _____ |
| Mental retardation | ☐ | ☐ | _____ |
| Autism or other developmental disorder | ☐ | ☐ | _____ |
| ADHD or learning disabilities | ☐ | ☐ | _____ |
| Alcohol or Drug dependency | ☐ | ☐ | _____ |
| Psychiatric disorder (depression, etc) | ☐ | ☐ | _____ |
| Seizures (specify type) | ☐ | ☐ | _____ |
| Nervous system disorder | ☐ | ☐ | _____ |
| Asthma or other lung disease (CF) | ☐ | ☐ | _____ |
| Allergies-seasonal (list allergens) | ☐ | ☐ | _____ |
| Allergies-food (list allergens) | ☐ | ☐ | _____ |
| Eczema or other skin conditions | ☐ | ☐ | _____ |
| Cleft lip or palate | ☐ | ☐ | _____ |
| Ear (infections, hearing loss, etc) | ☐ | ☐ | _____ |
| Eye (glaucoma, lazy eye, etc) | ☐ | ☐ | _____ |
| Anemia, clotting or bleeding disorders | ☐ | ☐ | _____ |
| Miscarriages (multiple) | ☐ | ☐ | _____ |
| Thyroid disease (high, low, cancer) | ☐ | ☐ | _____ |
| Gland or hormone problems | ☐ | ☐ | _____ |
| Childhood cancer | ☐ | ☐ | _____ |
| Adult cancer | ☐ | ☐ | _____ |
| Muscle or joint disease | ☐ | ☐ | _____ |
| Heart defect | ☐ | ☐ | _____ |
| Heart attack or stroke (before age 50) | ☐ | ☐ | _____ |
| High blood pressure | ☐ | ☐ | _____ |
| High cholesterol | ☐ | ☐ | _____ |
| Diabetes (specify type) | ☐ | ☐ | _____ |
| Kidney problems | ☐ | ☐ | _____ |
| Stomach problems (reflux, ulcers, etc) | ☐ | ☐ | _____ |
| Celiac, crohn's disease, ulcerative colitis | ☐ | ☐ | _____ |
| Anything else that “runs in the family” | ☐ | ☐ | _____ |