Patient Name_____ Date of Birth_____

FAMILY MEDICAL HISTORY (check all that apply)					
	Child's History	Child's Father	Child's Mother	Sibling (s)	Grand-parent
Heart attack					
High blood pressure					
High cholesterol					
Stroke					
Sudden death (before age 50)					
Other heart problems:					
Asthma					
Other lung problems:					
Allergies (e.g., food, environmental, seasonal)					
Other allergic/immune system problems:					
Eczema					
Other skin problems:					
Kidney Disease					
Recurrent childhood urinary tract infections					
Other kidney problems:					
Ulcerative colitis/Chron's disease					
Celiac disease					
Other gastrointestinal problems:					
Mental retardation/developmental delays					
Learning problems (e.g. dyslexia, etc)					
ADHD					
Depression/Anxiety					
Problems with addiction					
Other mental health problems:					
Hip dysplasia					
Genetic/birth defects					
Growth problems					
Thyroid problems					
Diabetes (before age 55)					
Other endocrine problems:					
Seizures					
Migraines					
Other neurologic problems:					
Glasses/vision problems in childhood					
Blindness					
Lazy eye (strabismus)					
Deafness					
Childhood cancers					
Bleeding/clotting problems					
Other:					