

FAMILY HISTORY

Have the parents, grandparents, or siblings of the patient had any of the following:

If yes, please explain **who**, what **age** diagnosed, and specific **details** about the type of condition.

Environmental allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Food allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Medication allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Autoimmune disorder (lupus, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding or clotting disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cystic fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes – insulin dependent (Type I)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes – non-insulin dependent (Type II)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chemical dependency (alcohol or drugs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eye or vision problems or blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing problem or deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Genetic abnormality (Down syndrome, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart attack or disease before age 55	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cholesterol above 240 or on medication for cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Immune problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
HIV or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Frequent bladder infections or bladder reflux / VUR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Kidney disease or needing dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Liver disease or hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach or intestinal problems (reflux, GERD, ulcers, Crohn's, ulcerative colitis, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Celiac disease or sprue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Menstrual or gynecologic problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Musculoskeletal disorders (scoliosis, osteoporosis, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Psychiatric or emotional disorder (depression, anxiety, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Autism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Mental retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Learning problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
ADD or ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Skin problem (eczema, psoriasis, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Spina bifida	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other _____			_____
Other _____			_____

Form completed by (print): _____ Relation to patient: _____

Signature: _____ Date: _____

We greatly appreciate your completing this form. It will help us to better care for your child.

Clinic Use: Provider review _____ Date _____