

FAMILY HISTORY QUESTIONNAIRE

Please complete **both sides** of this form **once**. We will copy this form for the charts of all siblings.

HOUSEHOLD

Please list all children in the family / household:

NAME	DATE OF BIRTH	CARED FOR BY WAYZATA CHILDREN'S CLINIC	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do all children in the family live with both biological parents? Yes No

If not, please describe the living situation: _____

What type(s) of home(s) do the patients live in?

Single family home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year built: _____
Duplex	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year built: _____
Apartment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year built: _____
Townhome / condominium	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year built: _____
Trailer / mobile home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year built: _____
Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Year built: _____

Is the family history for any patient unknown (for example, patient is adopted)? Yes No

If yes, name(s) of those with unknown family history: _____

If family history is known for any patient, please turn this page over and complete the other side.

FAMILY HISTORY

Have the parents, grandparents, siblings, aunts, uncles, or cousins of the patient(s) had any of the following:

(If more than one child in the family, please include history for all children, since we will copy this for all siblings' charts).

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	_____
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	_____
Menstrual or gynecologic problem	<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(s): _____

Signature: _____ Date: _____

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

Clinic Use: Provider review _____ Date _____