

PEDIATRIC FAMILY HISTORY FORM

DATE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_

Please indicate with an X any relatives with any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
ADD or Learning Disability									
Alcoholism or Substance Abuse									
Anemia									
Asthma									
Autism									
Autoimmune Disorder									
Bleeding or clotting Disorder									
Cancer Type: _____									
Congenital Anomaly/ Birth Defect									
Death before age 56 Cause: _____									
Depression or other mental health problem									
Diabetes									
Eczema									
Food Allergy									
Headaches or Migraine									
Heart Attack or Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Stroke									
Suicide									
Thyroid Disorders									
Tuberculosis									
Other:									

Please give any further details about the disorders above:

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