Patient Name _____ Birth date _____ Chart # _____

FAMILY HISTORY

(Circle pertinent problem and list affected family members)

Was your child adopted? Yes _____ No _____

Allergies – asthma, food, medicine, hay fever, other _____

Frequent strep throat or sinusitis or ear infections; hearing loss _____

Orthopedic problems – hip dysplasia, loose joints, other _____

Cancer _____

Heart problems – high blood pressure or cholesterol, other _____

Heart attack or stroke (age 50 yrs or less) _____

Intestinal problem – ulcer, colitis, gall stones, lactose intolerance, hepatitis, other _____

_____

Lung problem – emphysema, tuberculosis, pneumonia, other _____

Kidney problem – stones, infections, other _____

Neurologic problem – seizures, migraines, other _____

Blood problem – anemia, excess bleeding, jaundice, other _____

Skin problem – eczema, psoriasis, other _____

Crib death / sudden unexplained death _____

Eye problem – abnormal vision, glaucoma, blindness, other _____

Hormone problem – thyroid, child or adult diabetes, other _____

Emotional problem – depression, suicide, physical or sexual abuse, other _____

Cigarette / Alcohol abuse / Drug abuse _____

Learning problem – attention deficit, retardation, dyslexia, other _____

Arthritis, cystic fibrosis, dental problem, pregnancy problems, birth defects, eating disorder, other

_____

Who lives at home? _____ Pets? _____

What work do you do? _____ Your spouse? _____

Do you have helpful friends or family nearby? _____ Who? _____

Are your parents living? _____ Where? _____

Does anyone in the family smoke cigarettes? _____ Who? _____

Was your home built before 1960? _____

Circle those you have in the home: smoke alarm, fire extinguisher, Ipecac syrup (to induce vomiting), gun