FAMILY HISTORY

Date: _____

Patient Name: _____ Date of Birth: _____

Father (biological): _____ Age: _____

Mother (biological): _____ Age: _____

Medical Problems: _____

Siblings:

Name: _____ Age: _____

Medical Problems: _____

Name: _____ Age: _____

Medical Problems: _____

Name: _____ Age: _____

Medical Problems: _____

Name: _____ Age: _____

Medical Problems: _____

Medical conditions in biological aunts, uncles, cousins or grandparents: Please circle or write in:

SKIN: eczema, psoriasis, ichthyosis, other: _____

EYES: blindness, cataracts, lazy eye, other: _____

EARS: deafness, ear infections, deformities, other: _____

NOSE/THROAT: sinus problems, lack of sense of smell, tonsillitis, other: _____

MOUTH: cleft palate, cleft lip, other: _____

GLANDS: thyroid trouble, diabetes (adult), diabetes (juvenile), other: _____

LUNGS: asthma, cystic fibrosis, other: _____

HEART: murmurs, heart attacks, congenital abnormalities, high blood pressure, other: _____

_____

STOMACH/BOWEL: ulcers, colitis, lactose intolerance, other: _____

KIDNEY/BLADDER: congenital abnormalities, infections, kidney stones, other: _____

_____

BONE OR JOINT DISEASE: osteoarthritis, rheumatoid arthritis, osteogenesis imperfecta, other: _____

_____

NEUROLOGICAL PROBLEMS: seizures, paralysis, strokes, other: _____

_____

CANCER: _____

DEVELOPMENT PROBLEMS: _____

PSYCHIATRIC CONDITIONS: manic depressive (bipolar) disorder, schizophrenia, other: _____

_____

OTHER: _____

_____