The PEDIATRIC CLINIC

KIDS are at the heart of everything we do

Patient Name: **DOB**

FAMILY MEDICAL HISTORY									
Please indicate with an (X) or a check mark family members (child's parents, grandparents, aunts, uncles, brothers, sister) who have had any of the following conditions:									
Illness/Disease	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Please specify
Anemia/Bleeding Problems									
Asthma									
Allergies									
Alcohol use problems									
Bed-wetting (after age 10 yr)									
Cancer: Type									
Childhood hearling loss									
Dental Decay/multiple cavities									
Depression or Anxiety									
Developmental disability									
Diabetes									
Heart Attack									
Heart Disease (before age 55 yr)									
High Cholesterol									
High Blood Pressure									
Kidney Disease									
Liver Disease									
Mental Health Conditions									
Obesity									
Seizures or Epilepsy									
Stroke									
Substance Use Problems									
Sudden Death (before age 50 yr)									
Thyroid Disorder									
Tuberculosis									
Vision or eye problems									
Provider Reviewed: **Date:**									