

FAMILY MEDICAL HISTORY

Patient's Last Name _____ First Name _____

Date of Birth _____

Please complete the following with the name of consultants for this child.

Dentist: _____ Eye doctor: _____

Gynecologist _____ Other: _____

Check here if adopted. **Check here if there has been no change in any family history.**

Please check the box for any changes in medical history pertaining to the mother, father, siblings, (MGM) maternal grandmother, (MGF) maternal grandfather, (PGM) paternal grandmother or (PGF) paternal grandfather.

	Mother	Father	Siblings	MGM	MGF	PGM	PGF
Allergies							
Asthma							
Attention Deficit Disorder							
Autism/developmental issues							
Blood disorders/hemophilia							
Cancer (please specify type)							
Cardiac conditions (ie. murmurs, strokes, hypertension (please specify)							
Diabetes (please specify type)							
High Cholesterol							
Kidney Disease							
Mental Health/Substance Use (please specify)							
Obesity							
Strabismus (lazy eye)							
Stomach Issues (ie. Celiac/Crohns/IBD) (please specify)							
Thyroid disease							
Any other family history							
Deceased (Age/cause of death, if known)							

OFFICE USE ONLY
Reviewed/Entered: _____ (Initials) (Date)