Today's Date:_____

Name of Patient_____ DOB _____

FAMILY MEDICAL HISTORY- NEW PATIENT

Adoption? ❑ yes ❑ no Age at adoption?_____ What Country adopted from?_____

Has anyone in your family had: (parents, grandparents, aunts, and uncles)

Illness		Relationship	Illness		Relationship
High Blood Pressure	❑ yes ❑ no		Cleft Lip	❑ yes ❑ no	
Heart Attack at age <60	❑ yes ❑ no		Depression	❑ yes ❑ no	
Diabetes	❑ yes ❑ no		Drinking Problems	❑ yes ❑ no	
Stroke at age	❑ yes ❑ no		Drug Problems	❑ yes ❑ no	
Cancer	❑ yes ❑ no		Hearing Problems (not due to old age)	❑ yes ❑ no	
Thyroid Problems	❑ yes ❑ no		Skipped Heartbeats/Heart Rhythm Problems	❑ yes ❑ no	
Allergic Disorders (Hay fever, Eczema)	❑ yes ❑ no		High Cholesterol	❑ yes ❑ no	
Seizures	❑ yes ❑ no		HIV/AIDS Complex	❑ yes ❑ no	
Sickle Cell Anemia	❑ yes ❑ no		Hypertrophic/ Dilated Cardiomyopathy	❑ yes ❑ no	
Asthma	❑ yes ❑ no		Immune Disorders	❑ yes ❑ no	
Tuberculosis	❑ yes ❑ no		Kidney Problems	❑ yes ❑ no	
Mental Illness	❑ yes ❑ no		Learning Problems	❑ yes ❑ no	
Migraine Headaches	❑ yes ❑ no		Liver Problems	❑ yes ❑ no	
Anemia	❑ yes ❑ no		Long - QT Syndrome	❑ yes ❑ no	
Anxiety	❑ yes ❑ no		Lung Problems	❑ yes ❑ no	
Arthritis	❑ yes ❑ no		Malignant Hyperthermia	❑ yes ❑ no	
Bipolar Disorder	❑ yes ❑ no		Marfan Syndrome	❑ yes ❑ no	
Heart Malformation	❑ yes ❑ no		Mental Retardation	❑ yes ❑ no	
Bowel/ Intestinal Problems	❑ yes ❑ no		Suicide Attempt	❑ yes ❑ no	

PAST MEDICAL HISTORY

Check box if your child has or has had any of the following:

Attention Deficit Disorder?	❑ yes	❑ no	
Asthma?	❑ yes	❑ no	
Frequent wheezing or coughing spell?	❑ yes	❑ no	
Urinary Tract Infections?	❑ yes	❑ no	
Recurrent or Frequent Ear Infections?	❑ yes	❑ no	
Recurrent or Frequent Strep Throat?	❑ yes	❑ no	
Heart Murmur?	❑ yes	❑ no	
Ear Tube Replacement?	❑ yes	❑ no	If yes, what age? _____
Tonsillectomy?	❑ yes	❑ no	If yes, what age? _____
Adenoidectomy?	❑ yes	❑ no	If yes, what age? _____

SOCIAL HISTORY

Occupation: Father: _____

Mother: _____

Do you have Pets? ❑ yes ❑ no What kind?_____

Do you have ❑ city water ❑ well water

Are there any smokers in the home? ❑ yes ❑ no

Is your child in daycare (if under age 5)? ❑ yes ❑ no

Is your child home schooled? ❑ yes ❑ no

List names and date of birth of persons living with patient:

NAME	DOB	NAME	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____