NEW PATIENT FAMILY MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** ____/____/____

You do not need to fill this form out if you have already filled it out for another child with the same biological parents.

FAMILY - PAST MEDICAL HISTORY						
Biological Relatives Only	**Mom**	**Dad**	**Sister**	**Brother**	**Maternal Grandparents**	**Paternal Grandparents**
Nasal allergies or other allergies						
Asthma/lung disease						
Heart disease or heart condition						
High blood pressure						
High cholesterol						
Diabetes or other endocrine problem						
Cancer						
Anemia						
Bleeding disorders						
Epilepsy or convulsions						
Mental retardation or developmental disorders						
Neurological disorder including ADHD/ADD						
Liver disease						
Other GI disease/ disorder						
Kidney disease						
Bed-wetting (after age 10)						
Hearing impairment						
Eye Disorder						
Immune problems, recurrent infections or HIV-AIDS						
Alcohol Abuse						
Drug Abuse						
Mental Illness						
Tuberculosis						
Other issues:						

List any other family medical history: _____

_____

_____

_____

_____

_____

I attest that all the medical history information is true and correct to the best of my knowledge:

Print Name _____ Relationship to Patient _____

Signature _____ Today's Date _____/_____/_____