FAMILY HISTORY

PATIENT'S NAME: ________________________ DATE COMPLETED: ____________

MOTHER'S NAME: ________________________ FATHER'S NAME: ______________

PATIENT LIVES WITH: ____

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING PROBLEMS?

PROBLEM	NOT SURE	NO	MOM	MOM'S FAMILY	DAD	DAD'S FAMILY	OTHER CHILDREN IN FAMILY
CANCER							
EPILEPSY/SEIZURES							
DIABETES							
KIDNEY PROBLEMS							
HIGH BLOOD PRESSURE/ STROKE/HEART ATTACKS							
HIGH CHOLESTEROL							
HIGH TRIGLYCERIDES							
LUNG PROBLEMS/TB							
ALLERGIES/ASTHMA/HAY FEVER/ECZEMA							
DEAFNESS/HEARING PROBLEMS							
BLINDNESS/VISION PROBLEMS							
MENTAL ILLNESS/ NERVOUS BREAKDOWN							
SCHOOL PROBLEMS/ LEARNING DISABILITY							
BIRTH DEFECTS/ GENETIC DISORDERS							
CIGARETTE USE TOBACCO USE							
ALCOHOL USE							
DRUG USE							
SICKLE CELL ANEMIA OR SICKLE CELL TRAIT							
LEAD POISONING							
HIV INFECTION							
DEVELOPMENTAL DELAYS							
OTHER:							