Patient's Name_____

FAMILY MEDICAL HISTORY

Mother's Blood Type (if known)_____ Occupation:_____

Father's Blood Type (if known)_____ Occupation:_____

Family Medical History

Please check if condition is present in **any family member** and indicate how that person is related to the patient.

- ☐ Congenital heart disease_____
- ☐ Early heart attacks_____
- ☐ High cholesterol_____
- ☐ Cystic fibrosis_____
- ☐ High blood pressure_____
- ☐ Seasonal allergies_____
- ☐ Asthma_____
- ☐ Acid reflux_____
- ☐ Eczema_____
- ☐ Hirschprung's Disease_____
- ☐ Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis)_____
- ☐ Jaundice in the newborn_____
- ☐ Diabetes_____
- ☐ Thyroid disease_____
- ☐ Bleeding/clotting disorder_____
- ☐ Anemia/blood disease_____
- ☐ Cancer_____
- ☐ Autism Spectrum Disorder_____
- ☐ ADHD_____
- ☐ Seizure disorder_____
- ☐ Psychiatric disorder_____
- ☐ Urinary tract infection_____
- ☐ Kidney stones/other kidney disease_____
- ☐ Premature infant_____
- ☐ Twin/multiple births_____
- ☐ Sudden death at any age_____
- ☐ Tobacco use in family member_____
- ☐ Frequent ear infections_____
- ☐ Snoring/sleep apnea_____

Please note any other **family history** that you feel is important for us to know.

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Please check if any of the following **allergies** are present in the family.

☐ milk ☐ wheat ☐ eggs ☐ shellfish ☐ nuts/peanuts ☐ medications

Are there any other allergies or sensitivities in the family?_____