FAMILY HISTORY INTAKE FORM

Name of Child/ren: ____________________________________________

Please check (if applicable): Please discuss with your Provider.

Mother or Parent 1 alive and well  □ Yes  □ No….comments:

Father or Parent 2 alive and well  □ Yes  □ No….comments:

Brother 1  □ Healthy  □ Medical problems:

Brother 2  □ Healthy  □ Medical problems:

Sister 1  □ Healthy  □ Medical problems:

Sister 2  □ Healthy  □ Medical problems:

Any family history of:

**ASTHMA OR ALLERGIES:**

□ Asthma  □ Seasonal allergies  □ Food allergies

**AUTOIMMUNE PROBLEMS:**

□ Thyroid disease  □ Inflammatory bowel disease  □ Type I diabetes
□ Celiac disease  □ other:

**DEVELOPMENTAL PROBLEMS:**

□ Autistic spectrum disorder  □ Fragile X  □ ADHD
□ Significant learning disability  □ other:

**CARDIAC DISEASE:**

□ Very high cholesterol  □ Heart attacks in young adults  □ Cardiomyopathy
□ Prolonged QT syndrome  □ other:
RHEUMATOLOGIC DISEASES:

☐ Juvenile arthritis  ☐ Lupus  ☐ Ankylosing spondylitis
☐ other:

NEUROLOGIC DISEASES:

☐ Benign febrile seizures  ☐ Seizure disorder  ☐ other:

PSYCHIATRIC DISORDERS:

☐ Bipolar disorder  ☐ Schizophrenia  ☐ Depression  ☐ other:

MISC:

☐ Hearing loss  ☐ Bleeding / clotting disorders  ☐ Inherited genetic disorders
☐ other