

FAMILY HISTORY

CHILD/CHILDREN'S NAME: _____

FAMILY HISTORY (THINK IN TERMS OF THE CHILD'S SIBLINGS, PARENTS, GRANDPARENTS, AUNTS, UNCLES AND FIRST COUSINS):

ANY ALLERGIES, "HAY FEVER", ASTHMA OR ECZEMA? YES/NO
WHO? _____

ANY HEART ATTACKS, STROKES, OR HIGH CHOLESTEROL? YES/NO
WHO? _____ AT WHAT AGE? _____

ANY DIABETES (SUGAR)? YES/NO
WHO? _____

ANY EPILEPSY (SEIZURES)? YES/NO
WHO? _____

ANY CANCER? YES/NO
WHO? _____

ANY BLEEDING DISORDERS? YES/NO
WHO? _____

ANY ANEMIA OR SICKLE CELL? YES/NO
WHO? _____

ANYTHING ELSE YOU THINK WE SHOULD KNOW ABOUT?

THANK YOU FOR YOUR TIME. THIS INFORMATION WILL BE BENEFICIAL IN PROVIDING THE BEST POSSIBLE CARE FOR YOUR CHILD.