Patient's Name:_____

Date of Birth:_____

Date of Visit:_____

FAMILY HISTORY (CHECK IF PRESENT IN ANY OF YOUR CHILD'S SIBLINGS, PARENTS, AUNTS, UNCLES, FIRST-COUSINS OR GRANDPARENTS ON EITHER SIDE OF FAMILY)

- ☐ Spinal Bifida
- ☐ Vision/Eye Problems
- ☐ Bone Disorder
- ☐ Cerebral Palsy
- ☐ Chromosome Abnormality
- ☐ Anomalies (Includes Hydrocephaly)
- ☐ Cleft Lip/Palates
- ☐ Hearing Loss/Deafness
- ☐ Urinary Tract Abnormality
- ☐ Anemia (Includes Thalassemia)
- ☐ High Cholesterol/Triglycerides
- ☐ Attention Deficit/Learning Disorders
- ☐ Convulsions
- ☐ Heart Disease or Defect
- ☐ Infertility
- ☐ Neurofibromatosis
- ☐ Limb Defects
- ☐ Mental Retardation
- ☐ Cystic Fibrosis
- ☐ Mental Illness
- ☐ Short Stature (under 5ft)
- ☐ Tuberculosis
- ☐ Hay Fever or other Allergies
- ☐ Asthma
- ☐ Drug/Alcohol Problems
- ☐ Sickle Cell Anemia or Trait
- ☐ Bleeding Disorders
- ☐ Muscle Disorders
- ☐ Kidney Disease
- ☐ Brain Disorders
- ☐ Skin Disease
- ☐ Genital Abnormality
- ☐ Down Syndrome
- ☐ Neurological Disorders
- ☐ Other Birth Defects/Malformation
- ☐ High Blood Pressure
- ☐ Cancer

Please list any other problem(s) below:

_____

_____

_____

Please list the age, sex and health problems of brother and sisters. Please list if any sibling is deceased.

_____

_____

_____

_____