Pediatrics of Arlingon, PLC

Family Medical History Form

Today's Date: ____________

Child's Name: ______________________________ Birth date: ____________

	Name	Age		Name	Age
Mother:	__________________	______	Father:	__________________	______
Sibling 1:	__________________	______	Sibling 3:	__________________	______
Sibling 2:	__________________	______	Sibling 4:	__________________	______

Family History: Please indicate with a check the specified relatives with any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Allergies												
Anemia												
Asthma												
Autism												
Birth defects (type?)												
Bleeding/ clotting disorders												
Cancers												
cancer type?												
Developmental delays												
Diabetes												
Eating discorder/ obesity												
Eczema												
Epilepsy or seizures												
Genetic disorders												
Hearing loss												
Heart attack/ heart disease (age?)												
High blood pressure												
High cholesterol												
Immune deficiencies/ problems												
Kidney disease												
Mental illness												
Migraine headaches												
Scoliosis												
Smoker												
Substance abuse/ alcoholism												
Sudden death before age 50 years												
Thyroid disorders												
Other ?												