**When answering the Family History questions, please specify MATERNAL (mothers side) Grandmother or Grandfather and/or PATERNAL (fathers side) Grandmother or Grandfather**

## Family History

**Have any family members had the following:** **this would include - Mother, Father, Siblings, Maternal and Paternal Grandparents**

| | | | | |
|---|---|---|---|---|
| Deafness | ____ Yes ____ No | Who _____ | Comments _____ | |
| Nasal allergies | ____ Yes ____ No | Who _____ | Comments _____ | |
| Asthma | ____ Yes ____ No | Who _____ | Comments _____ | |
| Tuberculosis | ____ Yes ____ No | Who _____ | Comments _____ | |
| Heart disease (before 50 years old) | ____ Yes ____ No | Who _____ | Comments _____ | |
| High blood pressure (before 50 years old) | ____ Yes ____ No | Who _____ | Comments _____ | |
| High cholesterol | ____ Yes ____ No | Who _____ | Comments _____ | |
| Anemia | ____ Yes ____ No | Who _____ | Comments _____ | |
| Bleeding disorder | ____ Yes ____ No | Who _____ | Comments _____ | |
| Liver disease | ____ Yes ____ No | Who _____ | Comments _____ | |
| Kidney disease | ____ Yes ____ No | Who _____ | Comments _____ | |
| Diabetes (before 50 years old) | ____ Yes ____ No | Who _____ | Comments _____ | |
| Bed-wetting (after 10 years old) | ____ Yes ____ No | Who _____ | Comments _____ | |
| Epilepsy or convulsions | ____ Yes ____ No | Who _____ | Comments _____ | |
| Alcohol abuse | ____ Yes ____ No | Who _____ | Comments _____ | |
| Drug abuse | ____ Yes ____ No | Who _____ | Comments _____ | |
| Mental illness | ____ Yes ____ No | Who _____ | Comments _____ | |
| Mental retardation | ____ Yes ____ No | Who _____ | Comments _____ | |
| Immune problems, HIV, or AIDS | ____ Yes ____ No | Who _____ | Comments _____ | |

SMOKING ____Yes ____No Who_____ _____Inside _____Outside

## Past History

| **Does your child have, or has he/she ever had:** | | |
|---|---|---|
| Chickenpox | ____ Yes ____ No | When _____ |
| Frequent ear infections | ____ Yes ____ No | Explain _____ |
| Problems with ears or hearing | ____ Yes ____ No | Explain _____ |
| Nasal allergies | ____ Yes ____ No | Explain _____ |
| Problems with eyes or vision | ____ Yes ____ No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | ____ Yes ____ No | Explain _____ |
| Any heart problem or heart murmur | ____ Yes ____ No | Explain _____ |
| Anemia or bleeding problem | ____ Yes ____ No | Explain _____ |
| Blood transfusion | ____ Yes ____ No | Explain _____ |
| Frequent abdominal pain | ____ Yes ____ No | Explain _____ |
| Constipation requiring doctor visits | ____ Yes ____ No | Explain _____ |
| Bladder or kidney infection | ____ Yes ____ No | Explain _____ |
| Bed-wetting (after 5 years old) | ____ Yes ____ No | Explain _____ |
| (For girls) Has she started her menstrual periods? | ____Yes ____ No | When _____ |
| (For girls) Are there problems with her periods? | ____ Yes ____ No | Explain _____ |
| Any chronic or recurrent skin problems (acne, eczema, etc.) | ____ Yes ____ No | Explain _____ |
| Frequent headaches | ____ Yes ____ No | Explain _____ |
| Convulsions or other neurologic problems | ____ Yes ____ No | Explain _____ |
| Diabetes | ____ Yes ____ No | Explain _____ |
| Thyroid or other endocrine problem | ____ Yes ____ No | Explain _____ |
| Any other significant problem | ____ Yes ____ No | Explain _____ |
| Use of alcohol or drugs | ____ Yes ____ No | Explain _____ |