

# Family Medical History

**Dear Parents,** Please check any medical conditions which are present in your family, and who is affected by them, **based on their relationship to the child** (patient). Circle or write in any specific conditions that may apply.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Conditions	Child's Family	Child's Mother's Side of Family	Child's Father's Side of Family
<b>AIDS</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Allergy:</b> Eczema, hay fever, food allergy _____	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Arthritis, lupus</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Asthma</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Attention deficit disorder</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Birth defects</b> Hip dislocation, heart disease starting at birth	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Bleeding disorders,</b> hemophilia	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Blood disorders:</b> Anemia, sickle cell disease, thalassemia, spherocytosis, Rh disease, G6PD	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Cancer</b> Breast, colon, prostate, lung, skin, ovarian, other	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother

None of the above

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<b>Conditions</b>	<b>Child's Family</b>	<b>Family of Child's Mother</b>	<b>Family of Child's Father</b>
<b>Cholesterol or lipid elevation</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Cystic fibrosis</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Diabetes, Adult onset</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Diabetes, Juvenile</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Eye:</b> blindness, glaucoma, retinitis pigmentosa, congenital cataract, retinoblastoma	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Gastrointestinal Disorder</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Genetic disease:</b> PKU, Tay Sachs, muscular dystrophy	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Hearing problems, nerve deafness</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Heart attack before age 50</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Heart related sudden death</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother

None of the above

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<b>Conditions</b>	<b>Child's Family</b>	<b>Family of Child's Mother</b>	<b>Family of Child's Father</b>
<b>Hepatitis, liver disease</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Hypertension</b> (high blood pressure)	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Kidney disorders or failure</b> (Cystic kidney, recurrent urinary infections, reflux, kidney stones, malformation)	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Learning disability, dyslexia, autism</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Lung disease, emphysema</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Mental illness:</b> Depression, bipolar, schizophrenia, anxiety	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Mental retardation</b> Down syndrome, Fragile X	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Migraine</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Neurologic/Brain disorder:</b> Alzheimer, Parkinson, Huntington, multiple sclerosis, stroke, aneurysm	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Premature Birth</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother

None of the above

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<b>Conditions</b>	<b>Child's Family</b>	<b>Family of Child's Mother</b>	<b>Family of Child's Father</b>
<b>Psoriasis or other skin disorder</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Seizures, epilepsy</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Scoliosis</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Severe or recurrent infections</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Substance abuse, alcoholism, drug abuse</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Sudden infant death (SIDS), neonatal death, recurrent miscarriage</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Thrombosis or pulmonary embolism</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Thyroid disease (low or high)</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Tuberculosis</b>	<input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Mother's Brother <input type="checkbox"/> Mother's Sister <input type="checkbox"/> Mother's Father <input type="checkbox"/> Mother's Mother	<input type="checkbox"/> Father's Brother <input type="checkbox"/> Father's Sister <input type="checkbox"/> Father's Father <input type="checkbox"/> Father's Mother
<b>Other Family History</b> (write in)			

None of the above