Family History
For:
Date:

Mother's Name:__________________________ DOB:_____________ Height:____________

Cholesterol: Good________ High________ Unknown__________

Father's Name:__________________________ DOB:_____________ Height:_____

Cholesterol: Good________ High________ Unknown__________

Illness	Yes	No	Mother	Father	Grand mother	Grand father	Sibling	Comments
Example	**X**							**Thyroid medicine**
ADD								
Allergies								
Asthma								
Bed-wetting								
Birth Defects								
Bleeding Problems								
Cancer								
Cystic Fibrosis								
Depression (or other mental illness)								
Diabetes								Type I or Type II
Drug/Alcohol abuse								
Eczema/skin problems								
Eye glasses before age 5								
Head aches or migraines								
Hearing loss								
Heart attacks before age 50								
Heart disease (i.e. blood pressure, rhythm)								
Kidney Disease								
Learning Disabilities								

Pediatrics @the Basin

Illness	Yes	No	Mother	Father	Grand mother	Grand father	Sibling	Comments
Rheumatology immune disorders								
Scoliosis								Was surgery or bracing required?
Seizures/neurologic problems								
Sickle Cell								
SIDS/other infant death								
Sudden death (unexpected)								
Thyroid Disease								Low or high?
Vision problems unexplained								
Other:								
Elevated Cholesterol?								List most recent cholesterol for each parent:

Notes/Additional Concerns with family history: