PATIENT/FAMILY HISTORY

DR: _____

DATE: _____

Patient Name: _____ DOB: _____

Person Completing Form/Relationship to patient: _____

	Patient	Father	Mother	Brother	Sister	Father Side	Mother Side	List any specific information
Alcoholism/Drug/Tobacco Dependency								
Allergies (ex: hay fever, ragweed)								
Asthma/Wheezing								
Bedwetting								
Behavior Problems								
ADD/ADHD								
Aggressive Behavior								
Eating Problems								
Molestation								
Nervousness/Fidgety								
Learning/School Problems								
Birth Defects								
Blood Disorders (ex: Sickle Cell, anemia)								
Bone/Joint Disorders (ex: arthritis, gout)								
Cancer								
Cholesterol Problems								
Constipation								
Croup								
Developmental Problems								
Diabetes								
Eczema								
Fainting Spells								
Genetic Disorders (ex: Down Syndrome, Cystic Fibrosis)								
Heart Problems (ex: heart attack, hypertension, congenital)								
Hearing Problems (ex: deafness, hearing aids)								
Hepatitis								
Kidney Disease								
Lung Disorders (ex: tuberculosis, positive Tb test)								
Miscarriages/Stillbirth								
Mononucleosis								
Muscle Disorders (ex: Multiple Sclerosis, stiffness)								
Nervous Disorders (ex: migraines, seizures, epilepsy)								
Pneumonia								
Psychiatric Disorders (ex: depression, suicide, anxiety)								
Rheumatic Fever								
Sore/Strep Throat, Recurrent								
Speech Problems (ex: stuttering, delay, lisp)								
Stomach Problems (ex: ulcer, Crohn's disease, celiac)								
Sudden Death								
Thyroid Problems								
Urinary Tract Infections								
Venereal Disease (ex: herpes, gonorrhea, chlamydia)								
Vision Problems (ex: blindness, lazy eye, crossing eyes)								
Other:								
Have parents been divorced or separated?		YES	NO					

Physician Reviewed: _____