Please complete this family history form for your child

Patient's Name: _____ Today's Date: _____

Put an X for all of **your child's** biological relatives who have the condition. Comments:

CONDITION	Child's Mother	Child's Father	Child's Sister	Child's Brother	Child's Grandmother (Mother's side)	Child's Grandfather (Mother's side)	Child's Grandmother (Father's side)	Child's Grandfather (Father's side)	Child's Aunt(s)	Child's Uncle(s)	Child's Cousin(s)
ADHD/ADD											
Asthma											
Autism spectrum disorder, PDD-NOS, Asperger's											
Birth Defect											
Bleeding or clotting disorder											
Cancer before age 50											
Born with an eye/vision problem											
Born with hearing loss											
Born with a heart problem											
Diabetes											
Early heart disease (<55 in men, <65 in women)											
Genetic syndrome or condition											
High blood pressure											
High cholesterol or triglycerides											
Kidney Disease											
Mental or mood disorder											
Obesity											
Seizures											
Sudden cardiac death											
Other condition that affects 2 or more family members											
Does not have any of the conditions listed above											
No information about this relative											

Are the child's mother and father related to each other except by marriage? No__Yes ___ Do you have any other concerns about your child's family health history?

Any suggestions?_____