FAMILY MEDICAL HISTORY

Patient's Parents, Grandparents, Brothers, Sisters, First Cousins, Aunts and Uncles

ALL STAR PEDIATRICS

Child's Name: _____ Date of Birth: ____ / ____ / _____

Mother's Name: _____ Father's Name: _____

If siblings have **both** biological parents in common, please list below. If not, please request another form for sibling of different biological parents.

Name and Date of Birth of each sibling:

_____

CONDITIONS:	**YES**	**NO**	Please indicate family member (e.g. sister, paternal aunt, maternal grandfather, etc.) and provide details of condition (e.g. breast cancer, hypothyroid, peanut allergy, etc.)
Asthma			
Allergies			
Heart Disease (including coronary artery disease, congenital heart disease, mitral valve prolapse, irregular heart rate)			
High blood pressure			
Elevated cholesterol			
Cancer			
Anemia, bleeding or blood disorder including: (sickle cell disease or trait, thalassemia, hemochromatosis)			
Autoimmune disorder such as lupus or rheumatoid arthritis			
Thyroid disease			
Diabetes (type 1 or 2)			
Epilepsy, convulsions or other neurologic disorder			
Migraine headaches			
Developmental delay			
Autism			
Vision or hearing problems			
GI disorders (e.g. celiac, irritable bowel, Crohn's, ulcerative colitis)			
Liver disease			
Kidney disease			
Mental illness			
Alcohol or drug abuse			
Tuberculosis			
Birth defects			
SIDS or other childhood deaths			
Cystic fibrosis			
Hip dysplasia			

Other conditions: _____

Form completed by: _____ Relationship to child: _____ Date: ____ / ____ / _____