Family History

HAVE ANY OF CHILD'S PARENTS, GRANDPARENTS, AUNTS, UNCLES, BROTHERS, OR SISTERS HAD:

1. Bleeding from small injury, needing transfusion? ☐ No ☐ Yes
2. Sickle Cell Anemia? ☐ No ☐ Yes
3. Diabetes? ☐ No ☐ Yes
4. Asthma. ☐ No ☐ Yes
5. Eczema, Hay Fever or other allergies? ☐ No ☐ Yes
6. Mental problems (nervous breakdown)? ☐ No ☐ Yes
7. Seizures (convulsions, epilepsy, "falling out")? ☐ No ☐ Yes
8. Has anyone you know had tuberculosis? ☐ No ☐ Yes
9. Have any children or either parent died? ☐ No ☐ Yes
10. Is anyone at home seriously ill now? ☐ No ☐ Yes
11. Has the patient's mother had any miscarriages or still births? ☐ No ☐ Yes
12. History of Heart Attack or cholesterol problems before age of 50? ☐ No ☐ Yes
13. Name all persons in the home with age, relationship and health status.

Name	Age	Relationship	Health

WHY DID YOU BRING YOUR CHILD TO THIS OFFICE? (Chief Complaint)