PEDIATRIC HEALTHCARE ASSOCIATES **CHART #** ____________

Pediatric and Adolescent Medicine

Patient's Name __________________________ Nickname ______________ Date of Birth __________

FAMILY HISTORY:

	Date of Birth	Height	Illness
Father			
Mother			

	Illnesses	Age Died	Cause
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Does anyone in your family have any of the following diseases? If so, state the relationship to the patient.

	Yes	No	Relationship
Allergies			
Anemia			
Arthritis			
Asthma (lung problems)			
Birth Defects			
Blood Clots			
Cancer & type			
Diabetes			
Epilepsy (seizures)			
Gastrointestinal Disease			
Celiac Disease			
Heart Disease			
High Cholesterol			
Hypertension (high blood pressure)			
Immune Disorders			
Lazy Eye (Strabismus)			
Retinoblastoma			
Glaucoma			
Congenital Cataract			
Migraine Headaches			
Renal Disease (kidney problems)			
Rheumtologic Disorder			

	Yes	No	Relationship
Retardation			
Scoliosis			
Thyroid Disease			
Alcoholism			
Substance Abuse (drug use)			
Smoking			
Eating Disorder (bulimia/anorexia)			
Depression			
ADHD			
Other			