My Family History

Do any of the child's relatives have any of the following medical problems or conditions? Relative to the child, include mother, father, aunts, uncles, cousins, grandparents, and great-grandparents.

	✓ = YES			✓ = YES
Birth defects			Diabetes	
Cleft lip / palate			Hypertension (high blood pressure)	
Spina bifida			Heart Problems (structural, arrhythmias)	
Developmental disability			Sudden death before age 55	
Cerebral palsy			Hearing impairment	
Mental retardation			Allergies / Asthma	
Genetic conditions			Sickle cell disease / other blood disorders	
Metabolic or nutritional disorder			Elevated blood cholesterol levels	
Rheumatologic conditions / Arthritis			Kidney disease	
Stroke			HIV	
Seizure disorder / epilepsy			Cancer	
Mental / psychiatric illness			Other	

If 'Yes' was checked next to any of the items above, elaborate below. If multiple family members have the same medical problem, list them separately (one medical problem per person per line).

Disease / Condition	Relation to child	Age of onset	Date of death (if applicable)

Does anyone in the family have a disability, medical condition, or chronic illness similar to your child?	
☐ Yes ☐ No	If yes, please elaborate:

Has anyone in the family had genetic testing or counseling?	
☐ Yes ☐ No	If yes, please elaborate:

Is there any other familial medical history that may be relevant to your child's health care needs?	
☐ Yes ☐ No	If yes, please elaborate: