

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) |
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| Does anyone in the family have a disability, medical condition, or chronic illness similar to your child? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please elaborate: |

| | |
|---|---------------------------|
| Has anyone in the family had genetic testing or counseling? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please elaborate: |

| | |
|---|---------------------------|
| Is there any other familial medical history that may be relevant to your child's health care needs? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please elaborate: |