Pediatric & Adolescent Medicine, LLP

FAMILY HISTORY INTAKE FORM

Name of Child/ren: _____

Please check (if applicable): Please discuss with your Provider.

Mother or Parent 1 alive and well ☐ Yes ☐ No….comments:

Father or Parent 2 alive and well ☐ Yes ☐ No….comments:

Brother 1 ☐ Healthy ☐ Medical problems:

Brother 2 ☐ Healthy ☐ Medical problems:

Sister 1 ☐ Healthy ☐ Medical problems:

Sister 2 ☐ Healthy ☐ Medical problems:

Any family history of:

ASTHMA OR ALLERGIES:

☐ Asthma ☐Seasonal allergies ☐ Food allergies

AUTOIMMUNE PROBLEMS:

☐ Thyroid disease ☐ Inflammatory bowel disease ☐ Type I diabetes
☐ Celiac disease ☐ *other:*

DEVELOPMENTAL PROBLEMS:

☐ Autistic spectrum disorder ☐ Fragile X ☐ ADHD
☐ Significant learning disability ☐ *other:*

CARDIAC DISEASE:

☐ Very high cholesterol ☐ Heart attacks in young adults ☐ Cardiomyopathy
☐ Prolonged QT syndrome ☐ *other:*

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390 West End Avenue #1E / New York NY 10024 / 212-787-1444 / FAX 212-799-8620
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RHEUMATOLOGIC DISEASES:

☐ Juvenile arthritis ☐ Lupus ☐ Ankylosing spondylitis
☐ *other:*

NEUROLOGIC DISEASES:

☐ Benign febrile seizures ☐ Seizure disorder ☐ *other:*

PSYCHIATRIC DISORDERS:

☐ Bipolar disorder ☐ Schizophrenia ☐ Depression ☐ *other:*

MISC:

☐ Hearing loss ☐ Bleeding / clotting disorders ☐ Inherited genetic disorders
☐ *other*

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