FAMILY HISTORY/PREGNANCY HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

Is there a family history of the following? If so, how is the person related to your child? Please specify maternal or paternal family.

	NO	YES	RELATIONSHIP	MATERNAL	PATERNAL
Allergies or asthma					
Blood Problems					
Bowel or gallbladder disease					
Cancer					
Diabetes					
Eye problems or cataracts					
Glandular problems					
Hearing or ear problems					
Heart problems					
High Cholesterol					
Hip or joint problems					
Immmunologic problems					
Kidney disease or stones					
Mental problems					
Neurologic or learning problems					
Sexually transmitted disease Sudden Cardiac Death					
Sudden infant death syndrome					
Seizure or epilepsy					
Tuberculosis					
Urinary tract problems					
Anything else inherited?					

During mother's pregnancy, did she have:

diabetes or sugar problems		
blood pressure problems		
infections of:		
urine		
sexually transmitted disease		
other		
bleeding or clotting problems		
premature labor		
intake of:		
prescription or other medications		
alcohol		
tobacco		
drugs of abuse		

any fetal abnormality		