FAMILY HISTORY / PREGNANCY HISTORY

PATIENT'S NAME: _____ DATE OF BIRTH: _____

Is there a family history of any 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 / Asthma / Childhood asthma					
Blood problems					
G.I. disease					
Childhood cancer					
Diabetes					
Thyroid problems					
Hearing or ear problems					
Heart problems					
Immunologic problems					
Kidney disease or stones					
Mental health / Behavioral health:					
*Autism					
*ADHD					
*Anxiety / Depression					
*Bipolar					
*Attempted suicide					
Neurologic / Developmental / Learning problems					
Death < age 50 years					
Seizure or epilepsy					
Substance / Drug / Alcohol use					
Anything else inherited?					

During mothers pregnancy, did she have:	NO	YES
Any fetal abnormality		
Diabetes or sugar problems		
Blood pressure problems		
Infections of:		
*Group B Strep		
*Sexually transmitted infection		
*Other		
Bleeding or clotting problems		
Premature labor		
Intake of:		
*Prescription or other medication		
*Alcohol		
*Tobacco/Vape/Marijuana/Cannibis		