

## Genesis Pediatrics, LLC Family Health History

Family Name: \_\_\_\_\_

Doctor: \_\_\_\_\_

**A) Personal Histories (please use a second page for more than 3 children)**

	<i>First Child</i>	<i>Second Child</i>	<i>Third Child</i>
<b>Name</b>			
<b>Chronic Health Problems</b>			
<b>Medications</b>			
<b>Medication Allergies</b>			
<b>Food/Other Allergies</b>			
<b>Previous Surgeries</b>			
<b>Previous Hospitalizations</b>			
<b>Previous Injuries (fractures, etc)</b>			
<b>Chickenpox disease? (Y/N, with age if yes)</b>			

**B) Social History**

Please list everyone currently at home: \_\_\_\_\_

Any pets? List: \_\_\_\_\_

Any other care providers used (regular sitter, daycare)? \_\_\_\_\_

Does either parent or any caretakers smoke? \_\_\_\_\_

**C) Family History** including problem and relation (example: hypothyroid – maternal grandfather)

Include only close relatives (siblings, parents, grandparents, great-grandparents)

Medication Allergies		Heart Disease	
Food/Other Allergies		High Blood Pressure	
Migraines		Diabetes	
Seizures/Epilepsy		Bleeding Problems	
Strokes/Aneurysms		Anemia	
Depression/Anxiety		Skin Problems	
Substance Abuse		Cancers	
Thyroid Disease		Stomach Problems	
Lupus/Autoimmune		Vision Problems	
Asthma		Hearing Problems	
Contact with TB		Orthopedic Problems	
Speech Problems		Birth Defects	
Frequent Ear Infection		Other	

Anything not covered in the above history that you think it would be important for us to know about your child/children?

\_\_\_\_\_

\_\_\_\_\_