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Waldorf, MD 20603-4806

23000 Moakley Street
Suite 202
Leonardtown, MD 20650-2917

Patient Name: _____ DOB: _____ Appt Date: _____

Reason for today's visit: _____

Please indicate if there is a family history of any of the following.

Specify only mother, father, maternal-paternal grandparents and siblings.

Patient's mother's maiden name: _____

Y	N		If you mark yes please indicate who
☐	☐	Eczema	
☐	☐	Hearing Loss	
☐	☐	Allergies	
☐	☐	Asthma	
☐	☐	Cystic Fibrosis	
☐	☐	Hypertension	
☐	☐	High Cholesterol	
☐	☐	Heart Disease	
☐	☐	Stroke	
☐	☐	Congenital Heart Disease	
☐	☐	Inflammatory Bowel Dis.	
☐	☐	Polycystic Ovary Syn.	
☐	☐	Diabetes Type I	
☐	☐	Diabetes Type II	
☐	☐	Thyroid Disorder	
☐	☐	Anemia	
☐	☐	Bleeding Disorder	
☐	☐	Cancer	
☐	☐	Breast Cancer	
☐	☐	Headaches	
☐	☐	Epilepsy	
☐	☐	Development Delay	
☐	☐	Psychiatric	
☐	☐	ADD	
☐	☐	Sickle Cell	
☐	☐	Genetic	

Father's Height _____
Father's Health Status _____
Mother's Height _____
Mother's Health Status _____
# of Patient Siblings _____
Patient's Siblings' Health Status _____

Names of Patient's Siblings	Ages
_____	_____
_____	_____
_____	_____
_____	_____

Father's Occupation
_____

Mother's Occupation
_____

PETS IN THE HOUSE

☐ Dog ☐ Fish
☐ Cat ☐ Lizard/Turtle
☐ Bird ☐ Other

Exposure to second hand smoke

Y **N** If yes please indicate who

☐ ☐ _____

The child lives with:
☐ Mother
☐ Father
☐ Grandparent
☐ Other - Who?
_____

Parents' Status
☐ Married
☐ Divorced
☐ Separated
☐ Other-Please Specify
_____

Form completed by: _____

Relationship to the patient: _____