HOLYOKE PEDIATRIC ASSOCIATES

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Patient and Family Medical History

Patient Name: _____ Date of Birth: _____ Age: _____

Patient's Family Members: First & Last Name	Date of Birth	Medical Conditions
Parent:		
Parent:		
☐ Brother ☐ Sister		
☐ Brother ☐ Sister		
☐ Brother ☐ Sister		
☐ Brother ☐ Sister		
☐ Brother ☐ Sister		

Is the patient adopted? ☐ YES ☐ NO If yes, skip to bottom of page.

Is there any family history of the following?
If yes, who? ***Be specific*** *(Mom, Dad, Maternal or Paternal Grandparent, Sister, Brother, etc.)*

ADD/ADHD	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Anxiety	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Autism	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Asthma	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Bipolar	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Cancer	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Deafness	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Dental cavitites	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Depression	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Diabetes	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Elevated Cholesterol	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Hip Dysplasia/Hip dislocation	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Obesity/Overweight	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Migraines	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Schizophrenia	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Seizures	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Strabismus/Lazy Eye	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Substance Abuse (alcohol/drug)	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Sudden Death/Heart Attack before age 50	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	
Thyroid Disease	☐ YES	☐ NO	☐ PATIENT	☐ FAMILY MEMBER	

Parent's Occupation: _____ Parents' relationship status:

Parent's Occupation: _____ ☐ Single ☐ Married ☐ Divorced ☐ Other

Please complete both sides.
Revised 7/1/2022

List the people that live in the patient's home.

Name	Relationship to patient

Does the child live in another home part of the time? ☐ YES ☐ NO *If yes, list the people that live in that home.*

Name:	Relationship to patient:

Child Care (Facility or person who cares for the child)
Name: _____

Education
School: _____ Grade: _____

List current medications:

Medication/Herbs:	Dose:	How many times a day?	Prescribed by:

List hospitalizations and surgeries:

Date	Hospital:	Physician:	Reason for hospitalization/surgical procedure:

Name of person filling out form: _____ Relationship: _____ Date: _____