Berkeley Pediatric Medical Group

FAMILY HISTORY QUESTIONNAIRE

Only one copy of this page needs to be filled out per family. We will scan a copy in each child's chart.

Date: _____
Person Filling out this form: _____ Relationship to child: _____

PATIENT INFORMATION:

Child #1: _____ DOB: _____ Male ☐ Female ☐ Other: _____
Child #2: _____ DOB: _____ Male ☐ Female ☐ Other: _____
Child #3: _____ DOB: _____ Male ☐ Female ☐ Other: _____
Child #4: _____ DOB: _____ Male ☐ Female ☐ Other: _____

FAMILY HISTORY: PLEASE CHECK IF CHILD'S BIOLOGICAL RELATIVES HAVE ANY OF THESE CONDITIONS. USE THE BOTTOM OF THIS FORM IF EXTRA SPACE IS NEEDED.

	Y	N	Who was affected?	Explain
1. Allergies (Asthma, Eczema, Hay Fever, Food Allergies)				
2. Blood disorders (Bleeding, Clotting, Sickle Cell, Anemia)				
3. Bone/ Joint/ Rheumatic disorders (including hip problems in infants)				
4. Cancer (before 55 years old)				
5. High Cholesterol				
6. Diabetes (before 55 years old)				
7. Eye problems (blindness, lazy eye, crossing eyes)				
8. Ear problems (childhood hearing loss, hearing impairment, or hearing aid)				
9. Gastrointestinal Disorders (Celiac, Crohns, Ulcerative Colitis, GERD)				
10. Genetic disorders or Birth Defects (Cystic Fibrosis, Downs syndrome, Cleft Lip, Club Foot, Hip Dysplasia)				
11. Heart disease (Heart Attacks, arrhythmia) <65 years old for female, <55 years old for for males				
12. Hypertension/ high blood pressure				
13. Infectious diseases or problems with immune system (HIV, Tb, Immunodeficiency)				
14. Kidney problems				
15. Nervous system disorders (migraines, seizures, epilepsy)				
16. Obesity				
17. Psychiatric conditions (Depression, Anxiety, ADHD)				
18. Thyroid problems				
19. Alcoholism or Drug dependence				
20. Regular Smoker				
21. Bed Wetting (older than 10 years of age)				
22. Other				

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Reviewed By:_____