ROYAL OAK PEDIATRICS, P.C.

Name: ______________________ Number: ______________________

FAMILY HISTORY:

	Name	Age	Health
Parent:			
Parent:			
Siblings:			

FAMILY MEDICAL HISTORY:

Does any immediate family member (patient/parents/siblings) or second generation family memebers (grandparents/aunts/uncles) have a history of:

Condition			
Allergy	no	yes	____________
Asthma/Wheezing	no	yes	____________
Blood Disorder	no	yes	____________
Cardiac/Heart Problem	no	yes	____________
Cancer	no	yes	____________
Diabetes	no	yes	____________
Gastrointestinal/Liver Problem	no	yes	____________
Hearing Loss	no	yes	____________
High Cholesterol	no	yes	____________
High Blood Pressure	no	yes	____________
Immune Disorder	no	yes	____________
Genetic/Inherited Disorder	no	yes	____________
Kidney/Bladder Disorder	no	yes	____________
Lung Condition	no	yes	____________
Mental/Emotional Problem	no	yes	____________
Menstrual Problem	no	yes	____________
Neurological/Brain Disorder	no	yes	____________
Orthopedic/Bone Disorder	no	yes	____________
School/Learning Problem	no	yes	____________
Speech Delay	no	yes	____________
SIDS (Sudden Infant Death)	no	yes	____________
Skin Condition	no	yes	____________
Vision/Eye Problem (other than glasses)	no	yes	____________

Other ____

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