GREEN ROAD
PEDIATRICS, INC
Pediatric & Adolescent Medicine

Name: ___________________
DOB: ___/___/______

Family History

Please make note of any first or second degree relative (siblings, parents, grandparents only) of the patient with any of the following medical concerns/conditions:

	No	Yes - **relation**
Allergies (including seasonal & hay fever, food)	❑	❑
Anemia	❑	❑
Asthma	❑	❑
Autism or Pervasive Developmental Disorder	❑	❑
Bed-wetting (after 10 years old)	❑	❑
Birth defects	❑	❑
Bleeding disorder	❑	❑
Bone disease	❑	❑
Breast cancer	❑	❑
Diabetes (before 50 years old)	❑	❑
Eczema	❑	❑
Hearing problems	❑	❑
Heart disease(before 50 years old)	❑	❑
High blood pressure (before 50 years old)	❑	❑
High cholesterol (> or = 240)	❑	❑
Hip problems as a newborn	❑	❑
Immune problems (including HIV or AIDS)	❑	❑
Kidney disease	❑	❑
Liver disease	❑	❑
Lung disease	❑	❑
Marfan syndrome	❑	❑
Melanoma	❑	❑
Mental illness, including depression	❑	❑
Mental retardation	❑	❑
Neurofibromatosis	❑	❑
Recurrent bladder infections (as a child)	❑	❑
School learning problems	❑	❑
Scoliosis	❑	❑
Seizures/Convulsions/Epilepsy	❑	❑
Slow development or mental retardation	❑	❑
Stomach or intestinal problems	❑	❑
Substance abuse (alcohol and/or drugs)	❑	❑
Sudden death for no apparent reason	❑	❑
Tuberculosis	❑	❑
Urinary reflux	❑	❑
Vision problems (including wearing glasses)	❑	❑

Additional family history: ____

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