Kids Creek Children's Clinic
Family History Form

To help us give comprehensive care to your child please list any health problems in your family.
Please note: all relationships are from the child's perspective.
"Father" refers to the patient's father (and not yours!) ☺
If your child is adopted please complete to the best of your ability.

MEMBER	STATUS	CONDITIONS (Please Circle)
Patient's Father	Living? Yes No	Cancer Diabetes Heart disease under age 55 High Cholesterol Hypertension Alcohol/Drug abuse Kidney disease Mental illness Bleeding/clotting disorders Asthma Seizures Obesity Allergies_____ Other_____
Patient's Mother	Living? Yes No	Cancer Diabetes Heart disease under age 55 High Cholesterol Hypertension Alcohol/Drug abuse Kidney disease Mental illness Bleeding/clotting disorders Asthma Seizures Obesity Allergies_____ Other_____
Patient's siblings	Living? Yes No	Cancer Diabetes Heart disease under age 55 High Cholesterol Hypertension Alcohol/Drug abuse Kidney disease Mental illness Bleeding/clotting disorders Asthma Seizures Obesity Allergies_____ Other_____
Father's father (paternal grandfather)	Living? Yes No	Cancer Diabetes Heart disease under age 55 High Cholesterol Hypertension Alcohol/Drug abuse Kidney disease Mental illness Bleeding/clotting disorders Asthma Seizures Obesity Allergies_____ Other_____
Father's mother (paternal grandmother)	Living? Yes No	Cancer Diabetes Heart disease under age 55 High Cholesterol Hypertension Alcohol/Drug abuse Kidney disease Mental illness Bleeding/clotting disorders Asthma Seizures Obesity Allergies_____ Other_____
Mother's father (maternal grandfather)	Living? Yes No	Cancer Diabetes Heart disease under age 55 High Cholesterol Hypertension Alcohol/Drug abuse Kidney disease Mental illness Bleeding/clotting disorders Asthma Seizures Obesity Allergies_____ Other_____
Mother's mother (maternal grandmother)	Living? Yes No	Cancer Diabetes Heart disease under age 55 High Cholesterol Hypertension Alcohol/Drug abuse Kidney disease Mental illness Bleeding/clotting disorders Asthma Seizures Obesity Allergies_____ Other_____

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Patient History

Child's Name: _____Date of Birth_____

Current Medications

Name of Medication and Dosage	Name of Medication and Dosage
****Pharmacy #1 Name:**	****Pharmacy Location:**
****Pharmacy #2 Name:**	****Pharmacy Location:**

Allergies to Medications? Reaction/what happened?
Allergies to anything else? Foods/seasonal/environmental
Are there any smokers who live in the house? Yes/No Does anyone smoke in the home or car? Yes/No If so who?
Is your child biological or adopted?
Birth History? Birth weight _____ Delivery: Vaginal/C-section Prematurity?_____weeks Problems with pregnancy or delivery?
Patient's Past Medical History? (Please Circle) High blood pressure Diabetes Asthma/Wheezing Pneumonia Heart disease High cholesterol Frequent ear infections RSV Urinary tract infections Eczema Chickenpox Seizures Difficulty sleeping Reflux(Kidney or GI) Constipation Overweight Heart Murmur ADHD Anxiety Depression Bronchitis Other_____
List any surgeries, surgeon's names and year of surgeries:
List any hospitalization, reason admitted and patient's age:
Has your child had any significant injuries? Stitches, Broken bones? If so, where and at what age?
List names and relationships of all people living in <u>Patient's Mother's</u> home: (If Different) List names and relationships of all people living in <u>Patient's Father's</u> home:
Dad's Occupation:
Mom's Occupation: