

Family History

Have any family members had the following:

- | | | | | |
|-------------------------------------------|------------------------------|-----------------------------|-----------|----------------|
| Deafness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Heart disease (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High blood pressure (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bleeding disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Diabetes (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Epilepsy or convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Alcohol abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Drug abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental retardation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |

Additional family history _____

Past History

Does your child have, or has he/she ever had:

- | | | | |
|-----------------------------------------------------------|------------------------------|-----------------------------|---------------|
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Frequent ear infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with ears or hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with eyes or vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any heart problem or heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Anemia or bleeding problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Constipation requiring doctor visits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bladder or kidney infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bed-wetting (after 5 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| (For girls) Has she started her menstrual periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| (For girls) Are there problems with her periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any chronic or recurrent skin problem (acne, eczema, etc) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Convulsions or other neurologic problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Thyroid or other endocrine problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any other significant problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Use of alcohol or drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |