

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 _____