

ORCHARD PEDIATRICS, PC

2011 FAMILY HISTORY

Please list the legal name of all children that are patients in this office:

<u>NAME</u>	<u>BIRTHDATE</u>
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

AFFECTED FAMILY MEMBER

<u>YES</u>	<u>NO</u>		<u>Father</u>	<u>Mother</u>	<u>Sibling</u>	<u>Grandparent</u>	<u>Aunt/Uncle</u>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer before age 50	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes before age 40	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Heart Attack < age 65 women & < age 55 men	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol (over 240 without medicine) or Triglycerides	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia or Bleeding Disorder (specify type)	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Inherited diseases	_____	_____	_____	_____	_____

If yes, specify type, as well as person affected _____

Other, including intellectual disability, psychiatric or any other disorder not mentioned above: (You can add anything you think we should know about in the family history that is not covered above and may affect the care of your child)

SIGNATURE AND RELATIONSHIP TO CHILD DATE

DOCTOR SIGNATURE DATE