Family Health Screening

Immediate Family

Patient Name: Date of Birth:

	Yes	No	Who	Comments
Deafness				
Allergies (food or environmental)				
Asthma				
Tuberculosis				
Heart disease/sudden death (before 50 yrs)				
High blood pressure (before 50 yrs)				
High cholesterol				
Anemia/Bleeding disorder				
Liver/Kidney disease				
Diabetes (before 50 yrs)				
Epilepsy or convulsions				
Alcohol/Drug abuse				
Tobacco use				
Mental illness/depression				
Mental retardation				
Immune problems/HIV/AIDS				
Cancer				
Gastrointestinal problems				
ADHD or Anxiety				

Past History

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

	Yes	No	When/Explain
Chicken Pox			
Frequent ear infections/hearing loss			
Allergies (food or environmental)			
Problems with eyes or vision			
Asthma, bronchitis, bronchiolitis, or pneumonia			
Any heart problem or murmur			
Anemia or bleeding problem			
Frequent abdominal pain/constipation			
Bladder or kidney infection			
Bed wetting (after 5 yrs. Old)			
Problems with menstrual period			
Chronic or recurrent skin problems			
Frequent headaches			
Convulsions/ neurological problems			
Diabetes			
Thyroid/endocrine problems			
Alcohol/Drug use			
Other significant problems			

Home Environment – Please check all that are in the household where the child resides:

□ Smokers □ Smoke detectors □ Pets _____

□ Guns/Firearms □ Carbon monoxide detectors