Name:_____ D.O.B.:_____ Chart #:_____

	Your Child's									
	Mom	Dad	Brother	Sister	Mom's Mother	Mom's Father	Dad's Mother	Dad's Father	Mom's Sibs	Dad's Sibs
Asthma										
Allergies - Seasonal										
Allergies - Food										
Allergies - Medications										
Milk Intolerance										
Diabetes Type 1 or Type 2										
Kidney Disease and type of disease										
Seizure Disorder and type										
History of inherited bleeding disorder										
Sickle Cell Disease (SS or SC disease)										
Tuberculosis										
Stroke										
Heart Attack/Age when happened										
Congenital heart disease (as infant/child)										
High Cholesterol										
High Blood Pressure										
Cancer and type										
Mental Retardation										
Learning Disorder										
Attention Deficit Disorder										
Bipolar or Schizophrenia										
Depression										
Thyroid Problems										
Lupus										
Chrons										
Ulcerative Colitis										
Gastrointestinal reflux disease/heartburn										
Irritable Bowel Syndrome										
Congenital hearing loss										
Liver Disease										
Migraine Headaches										
Deceased/age										
HAS YOUR CHILD HAD:										
Any previous hospitalizations?										
Any previous surgeries?										
Any previous significant injuries (fracture/concussion)										