Patient Name _____ **Date** _____

****PLEASE CHECK POSITIVE RESPONSES ONLY****								
Main Street Pediatrics **Family History**	Mom	Dad	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Notes
Height								
Weight								
Asthma								
Seasonal Allergies								
Food Allergy								
Eczema								
High Blood Pressure								
High Cholesterol								
Heart Attack: Men <55, Women <65								
Sudden Death								
Heart Defect at Birth								
Diabetes Type I								
Diabetes Type II								
Thyroid Disease								
Obesity								
Age of Menstrual Period/Growth Spurt								
Sickle Cell Disease/Trait								
Clotting or blood disorder								
Crohn's Disease								
Ulcerative Colitis								
Gastroesophageal Reflux								
Kidney Disease or kidney stones								
Urinary Reflux								
Lazy Eye								
Deafness								
Mental Retardation								
Chromosomal Abnormality								
Autism								
Learning Disabliity								
Attention Deficit Disorder								
Seizure Disorder								
Migraine Headaches								
Anxiety								
Depression								
Schizophrenia								
Alcoholism								
Substance Abuse								
Breast Cancer								
Ovarian Cancer								
Colon Cancer								
Testicular Cancer								
Melanoma								

Physician_____