FAMILY HISTORY FOR:

Place First and Last Name and Birthdate for ALL of your children's biological relatives, *then mark an "X" in the column, if they have any of these conditions. Write any additional family history (aunts, uncles, and cousins with important conditions) on the back of this sheet. Penn State Health Medical Group - All About Children*	ADD/ADHD	Anemia	Asthma	Autism spectrum	Birth defect	Bleeding or clotting problem	Cancer	Celiac disease/gluten intolerance	Depression	Diabetes	Eye/vision problem	Gout	Hearing problem	Heart problem	Heart attack	Heart surgery	Headaches	Hepatitis	High blood pressure	High cholesterol or lipid problem	HIV / AIDS	Inherited problem	Kidney problem	Lung Problem	Mental Health Problem	Obesity/Overweight	Seizures	Stroke	Sudden Death	Other condition that affects 2 or more family members	None of these conditions affect	No information about this	This relative has died	Cause of death
Child's Sister or Brother **(e.g. Jane Doe-5/3/2001)**																																		
Child's Sister or Brother																																		
Child's Sister or Brother																																		
Child's Sister or Brother																																		
Child's Mother																																		
Mom's brother/sister																																		
Mom's brother/sister																																		
Child's Father																																		
Dad's brother/sister																																		
Dad's brother/sister																																		
Mom's Mother																																		
Mom's Father																																		
Dad's Mother																																		
Dad's Father																																		
Other family members with health problems																																		
Other people who live in your house:																																		

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