Patient Name:_____

Medical Record Number:_____

Triad Adult and Pediatric Medicine
Health History Form
Pediatrics

FAMILY HISTORY UPDATE				
Does anyone in your family, on either mother's or father's side, have any of the following?				
No	**Condition**	**For example**	**Yes**	**If yes, who in family?**
□	allergy	any particular food, pollen	□	
□	anemia	sickle cell disease, or trait; or other trait	□	
□	asthma		□	
□	ADHD	attention deficit and/or hyperactivity	□	
□	autism		□	
□	breast cancer		□	
□	colon cancer		□	
□	lung cancer		□	
□	ovarian cancer		□	
□	other cancer	any other, like skin or brain	□	
□	cardiovascular disease	heart attack, high blood pressure, stroke	□	
□	death, sudden cardiac	sudden death, with no reason known, under age 50	□	
□	diabetes mellitus		□	
	digestive disease	severe reflux		
□	elevated cholesterol	high cholesterol	□	
□	epilepsy	seizures	□	
□	genetic disease	Down, cystic fibrosis, or other disease	□	
□	hearing loss/deafness		□	
□	immune disorder/disease	sarcoid, thyroid, lupus, immune deficiency	□	
□	infectious disease	HIV, hepatitis, TB or positive TB test	□	
□	kidney disease	dialysis, abnormal kidney, single kidney	□	
□	learning problem	schoolwork problems, dyslexia	□	
□	intellectual disability	mental retardation	□	
□	musculoskeletal disease	arthritis, osteoporosis	□	
□	obesity		□	
□	psychiatric condition	depression, anxiety, bipolar, suicide	□	
□	skin condition	psoriasis, eczema	□	
□	substance abuse	drug or alcohol problems	□	
□	vision loss/blindness	eye problems, blindness, glaucoma	□	
□	other	anything not mentioned in this list	□	
OTHER QUESTIONS				
Since your last visit here, has your child been to any hospital, emergency room, or urgent care? yes □ no □				
Since your last visit here, has your child seen any specialist? yes □ no □				
Is your child getting any therapy, either at home or in another place? yes □ no □				