Stanford Children's Health | Lucile Packard Children's Hospital Stanford

FAMILY HISTORY FORM

Patient Name:

DOB:

FAMILY HISTORY: Please check all that apply for each relative (√). M- indicates Maternal P- indicates Paternal

Relationship	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Learning Disabilities	Mental Illness	Mental Retardation	Miscarriages	Stroke	Vision Loss
Mother																					
Father																					
Sister																					
Brother																					
Daughter																					
Son																					
Maternal Aunt																					
Maternal Uncle																					
Paternal Aunt																					
Paternal Uncle																					
MGM																					
MGF																					
PGM																					
PGF																					

Please indicate other major family illnesses not listed above: _____

Please indicate here if the patient was adopted Yes ____ No ____

Please indicate here if there is no family history available _____

How many siblings does the patient have? _____

If yes, please list names of siblings _____

Has the patient had any surgeries or hospitalizations?

If so, please explain _____