Child's Name:_____ Birthdate: _____ Please complete this Family Medical History form for your child

Please place First and Last Name and Birthdate in each block below and an "X" in the column for all of you child's biological relatives who have the condition. Please write any additional family history (aunts, uncles, and cousins with important conditions) on the back of this sheet. Thank you. AACPP Staff	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 this family member	No information about this family member	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: