FAMILY MEDICAL HISTORY (please check if yes there is a history of)

Patient first and last name:_____ _____**Patient DOB:**_____

Condition	Mother	Father	Blood Brother/Sister or half sibling	Grandmother/Grandfather indicate which side of family Mother/Father	Other/Who?
Allergies					
Anemia					
Arthritis					
Asthma					
Birth defects					
Cancer					
Diabetes					
Emotional/Psychiatric					
Eye/Vision problems					
Hearing problems					
Heart problems					
High Blood Pressure					
High Cholesterol					
Kidney disease					
Learning disabilities					
Lung disorders					
Migraines					
Neurological					
Scoliosis					
Seizures					
Thyroid conditions					

Please answer the following questions about blood relative family history	Circle Yes or No
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, long QT syndrome, short QT syndrome, Brugada syndrome, or clinically important arrhythmias (abnormal heart rhythms)?	Yes No
Has any family member or relative died of heart problems or had an unexpected sudden death before age of 50?	Yes No
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	Yes No

Please list an;y other family medical history you feel is pertinent to your child's care: _____

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