
FAMILY HISTORY

Child's Name: _____

Does anyone else in family have a similar condition to the child? NO YES (If Yes, please explain on the lines below)

Do any relatives or members of your immediate family have the following condition (list relationship to child):

- 1. Diabetes _____
- 2. Heart Problems _____
- 3. Hearing Impairment _____
- 4. Vision Impairment _____
- 5. Allergies/Asthma _____
- 6. Seizure Disorder _____
- 7. Cerebral Palsy _____
- 8. Mental Retardation _____
- 9. Cleft Palate _____
- 10. Birth Defects _____
- 11. Other _____

Have you, or has anyone in your family, had genetic counseling? NO YES (If Yes, please explain on the lines below)

TIP: Family medical history forms may contain references to "maternal" or "paternal" relatives. "Maternal" means on the mother's side of the family; "paternal" means on the father's side of the family.