Today's Date _____

FAMILY HISTORY

Family Name: _____ Who lives in your home? _____

List Children: Name Date of Birth Sex General Health Cell # if >13 yrs. old

_____

_____

_____

_____

Parent/Guardian Information

Marital Status: married / single / divorced / separated / widowed

Parent/Guardians name: _____
DOB: _____ Occupation: _____
Cell Phone: _____
General health: _____
Relationship to child(ren): _____
Primary caregiver? Yes No

Parent/Guardians name: _____
DOB: _____ Occupation: _____
Cell Phone: _____
General health: _____
Relationship to child(ren): _____
Primary caregiver? Yes No

Has anyone in the family had: (parents, grand-parents, aunts/uncles, cousins)

Allergies (list)	yes	no	If yes, how related	comments
Asthma				
TB / Lung disease				
HIV/Aids				
Suicide Attempts				
Heart Disease				
High Blood Pressure/Stroke				
High cholesterol				
Blood Disorders / Sickle Cell				
Diabetes				
Seizures				
Depression/Mental Illness				
Cancer				
Birth Defects				
Hearing Loss				
Speech Problems				
Kidney Disease				
Alcohol/Drug Abuse				
Hepatitis/Liver Disease				
Thyroid Disease				
Learning Problems/ Attention Deficit Disorder				
Family Violence				
Childhood Death / Sudden Death				