FAMILY HISTORY

DATE: _____

PARENTS NAME: _____

RESPONSIBLE PARTY: _____

CHILD'S NAME:	DATE OF BIRTH:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

ANY HEALTH ISSUES IN YOUR CHILDREN: _____

_____

_____

_____

PLEASE INDICATE ANY OF THE FOLLOWING THAT MAY AFFECT A MEMBER OF YOUR FAMILY:

PLEASE CHECK:	FAMILY MEMBER:
( ) HEART DISEASE:	_____
( ) DIABETES:	_____
( ) HIGH BLOOD PRESSURE:	_____
( ) ASTHMA:	_____
( ) ALLERGIES:	_____
( ) CYSTIC FIBROSIS:	_____
( ) KIDNEY DISEASE:	_____
( ) MENTAL ILLNESS:	_____
( ) THYROID DISEASE:	_____
( ) CANCER: (IN CHILDREN)	_____
( ) CROHN'S DISEASE/IRRITABLE BOWEL:	_____
( ) STROKE:	_____
( ) SMOKER:	_____
( ) DRUG PROBLEM:	_____
( ) OTHER:	_____

NORTHEAST PEDIATRIC ASSOCIATES, P.C.
Barclay Medical Plaza, 75 Barclay Circle, Suite 115, Rochester Hills, MI 48307