Garden City Pediatric Associates
Interval Family History Update

Name of Child/Patient: Date of Birth Today's Date

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Names of Parents (Guardians): Age Occupation

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Names of brothers and sisters: Age Date of Birth

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Who else is living at home? Age Relationship

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Parents are (please circle): single married separated divorced deceased

Are there any smokers who live in the home? yes no

Please circle if blood relatives of child/patient have had any of the following:
(Include patient's parents, brothers, sisters, and grandparents. Write in which relative has each condition.)

Asthma
Eczema
Allergies
Food Allergies

Frequent ear infections
Lazy eye

Anemia
Bleeding problems
Thyroid disease

Headaches
Migraines
Seizures

High blood pressure
High Cholesterol
Diabetes

Skin cancer

Learning problems
ADD/ADHD

Mental Illness
Depression
Anxiety
Alcoholism
Suicide