Bloom Pediatrics
Where Good Health Grows

Family History

Patient Name:________________________________Date of Birth:________________ Today's Date:________________

Do any of your **CHILD'S** biologic **parents**, **siblings**, or **grandparents** have the following conditions for which they are followed by a doctor or treated with medications regularly? Please CIRCLE any that apply.

Condition – please circle	Who	Details / Comments
ADHD		
Allergies (please list to what: hayfever, food, medications)		
Anemia		
Asthma		
Arthritis, Autoimmune disease		
Autism or developmental disability		
Bedwetting after 7 years old		
Bleeding or clotting disorders		
Cancer (please list type)		
Childhood hearing loss/Deafness		
Colitis (Crohn's, Ulcerative Colitis, Celiac disease)		
Depression, anxiety, or other mental illness (please specify)		
Dental decay or significant cavities		
Diabetes (specify adult or child onset)		
Drug/Alcohol abuse		
Eczema/Skin disorders		
Epilepsy or seizures		
Heart disease before 55 years old		
High blood pressure		
High cholesterol		
Hip dysplasia		
Kidney disease		
Lazy eye/Strabismus		
Learning disability		
Liver disease		
Migraine headaches		
Neurologic disorders (seizures, multiple sclerosis, other)		
Obesity		
Stroke before 55 years old		
Sudden death before 55 years old		
Suicide		
Thyroid disorders		
Tobacco use/Vaping		
Tuberculosis		

Additional Family History:____