Boulevard Pediatrics

Family Medical History

Child's Name (First, Middle, Last)

_____

Date of Birth _____ Gender _____

Please indicate all known health conditions that apply to your child's immediate family including parents, siblings, grandparents, aunts/uncles, and 1st cousins.
If your child is adopted, please include ANY information you may have about his/her biologic parents/family.

Health Condition

Asthma/Allergies: _____

Blood Disorders (e.g. hemophilia, sickle cell disease, clotting disorders):

_____

Cancer: _____

Cardiovascular Disease (including high cholesterol and high blood pressure):

_____

Cerebrovascular Disease (e.g. stroke, aneurysm)

_____

Developmental Disorders (e.g. pervasive developmental disorder, autism):

_____

Diabetes: _____

Endocrine Disorders (e.g. hypo (hyper) thyroid):

_____

Epilepsy (seizure disorder): _____

Eye Condition(s) (including at what age glasses were first worn):

_____

Psychiatric Conditions (e.g. depression, bipolar):

_____

Rheumatologic Disorders (e.g. rheumatoid arthritis, lupus):

_____

Skin Conditions (e.g. eczema): _____