Ridgewood Pediatrics, LLC

Family History Form

Mother's Name: _____ D.O.B.: _____

Father's Name: _____ D.O.B.: _____

BIRTH HISTORY

Gestational Age: ____ Vaginal or C-Section: _____ Birth Wt: ____ Discharge Wt: ____

Length: _____ HC: _____ Breastfeeding: Y/N? _____ Birth Hospital:_____

FAMILY HISTORY

Mother's Age: _____ # of Pregnancies: _____ Do you smoke? _____

Health Problems:

_____

_____

Father's Age: _____ Do you smoke? _____

Health Problems:

_____

_____

Siblings:

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Name: _____ Age: ____ D.O.B.: _____ Health Problems: _____

Please indicate if there is any family history of: (Circle all that apply)

Allergies	Hearth Disease	High Cholesterol	Drug/Alcohol Use	Stroke
Asthma	Kidney Problems	Seizures	Psychiatric Disorder	SIDS
Anemia	Diabetes	Intestinal Problems	Bleeding	Cancer
High Blood Pressure		Metabolic Disorder	Inherited Illnesses	Others

Please specify any other problems that you think might be helpful to us in the care of your child:

_____

_____

_____