



Berkeley Pediatric Medical Group

Family History Questionnaire

Only one copy of this page needs to be filled out per family. We will scan a copy in each child's chart.

Date: _____

Person filling out this form: _____ Relationship to child(ren): _____

Patient information:

Child #1 _____ DOB: _____ Male Female Other: _____

Child #2 _____ DOB: _____ Male Female Other: _____

Child #3 _____ DOB: _____ Male Female Other: _____

Child #4 _____ DOB: _____ Male Female Other: _____

Is your child adopted? yes no

Was your child conceived with donor egg/sperm? yes no

If yes to any of the above questions, please complete one form per child based on the child's known genetic history.

Please fill this form out based on the child's genetic history. Use the space below to provide any additional information as needed.

Family Medical History			
	No	Yes	Relationship to Patient
Asthma / Lung Disease			
Allergies - environmental, food, medication			
Eczema			
Thyroid problems			
Diabetes			
Heart disease before age 55			
High Blood Pressure			
Kidney Disease			
Blood Disorders			
Hereditary Cancers			
Developmental Disability			
Epilepsy / Neurological Disorders			
Depression / Anxiety / ADHD / Mental Illness			
Substance Use			