

Medical / Family History

Patient Name: _____
 Patient DOB: _____
 Physician: _____
 Date of service: _____

	Maternal	Family
Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorder (ie: Lupus/ Arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/ clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder (Hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine use	<input type="checkbox"/>	<input type="checkbox"/>
Canavan Disease (Neuro Brain Disorder)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chromosomal anomaly (ie: Downs))	<input type="checkbox"/>	<input type="checkbox"/>
Congenital anomaly (ie:cleft lip)	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>

Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Multiple gestations	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal condition	<input type="checkbox"/>	<input type="checkbox"/>
Neural tube defect (ie: spina bifida)	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Phenylketonuria (PKU disease)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>
Rh incompatibility (RH NEG)	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>

	Maternal	Family
DES exposure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Drug use	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine disorder (Adrenal/ Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to cat feces	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>
General anesthesia/ reaction	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
HIV/ AIDS	<input type="checkbox"/>	<input type="checkbox"/>
HPV (Genital Warts/ ABNL PAP)	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>

Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell trait	<input type="checkbox"/>	<input type="checkbox"/>
Tay-Sachs disease	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia (ie: type of anemia)	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
UTI/ recurrent	<input type="checkbox"/>	<input type="checkbox"/>
Uterine anomaly	<input type="checkbox"/>	<input type="checkbox"/>
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Violence (to you, or by you)	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>