EAST VALLEY CHILDREN'S CENTER Date _____ Chart No. _____

FAMILY HISTORY

Father:

First Name_____ Last Name _____ Birth Date_____ Ht_____ Wt_____

Occupation_____ Overall Health: () Excellent () Good () Fair () Poor

Mother:

First Name_____ Last Name _____ Birth Date_____ Ht_____ Wt_____

Occupation_____ Overall Health: () Excellent () Good () Fair () Poor

Children:

Name_____ B.Date___/___/___ Health _____ Name_____ B.Date___/___/___ Health _____

Name_____ B.Date___/___/___ Health _____ Name_____ B.Date___/___/___ Health _____

Name_____ B.Date___/___/___ Health _____ Name_____ B.Date___/___/___ Health _____

Name_____ B.Date___/___/___ Health _____ Name_____ B.Date___/___/___ Health _____

Family Medical History:

Please indicate any relatives of your children with the following conditions:

Neurological	*Endocrine*	*Pulmonary*	*Cardiac*	*Miscellaneous*
Seizures w/Fever	Diabetes	Asthma	Heart Attack	SIDS
Mental Retardation	Thyroid	Cystic Fibrosis	Heart Defects	Drug Use
Epilepsy	Adrenal	Chronic Bronchitis	High Cholesterol	Alcoholism
		Emphysema	High Bp	Hayfever

Please list any disorders or conditions in family members that are not listed above:

Grandparents of your children (parents of father & mother):

Please indicate current age, medical conditions, age at death & cause of death if no longer living, of each grandparent of your children:

Relation	Age	Current Medical Condition	Age @ Death	Cause of Death
Mother's Mother				
Mother's Father				
Father's Mother				
Father's Father				

Home:

Indoor Pets: () Dog () Cat () Bird () Other _____

Smoking in the Home () Number of Adults in the Home: _____ Number of Children in the Home _____

Religious Preference _____ (optional

Additional Information::

Please indicate any additional information about your family or home that you feel would be helpful in caring for your children.

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