Drs. Roth, Rotter & Laster

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Family History Form

Child's Name: _____ Male Female Birthdate: _____
Last First

Today's Date: _____

Parent/Mother	Parent/Father
Mother's birthdate	Address
Address	Profession
Profession	Employer
Employer	Phone
Phone	Email
Email	Parents are:
Health Insurance	Single Married Separated Divorced Widowed
Policy Number	
Subscriber	Delivery Hospital
Social Security # of Subscriber	Obstetrician
Referred by	Due Date

Child's Birth History

During your pregnancy with this child, did you:

Have high blood pressure?	Yes	No
Have diabetes or sugar in your urine?	Yes	No
Take any prescription medicine?	Yes	No
Smoke cigarettes?	Yes	No
Have a drug or alcohol dependency?	Yes	No
If yes please explain		
Other conditions:		
How long was your pregnancy?		
Was more than one baby born?	Yes	No
Did you have a difficult delivery?	Yes	No
Was it a cesarean section?	Yes	No
Was anything wrong with the baby?	Yes	No
If yes, what?		

Maternal and Family History

How many children have you (mother) had?	
Which one is this child?	
Ages of all child's siblings?	
Have you had any premature births?	
Have you had any miscarriages?	
Mother's age now	Mother's height
Father's age now	Father's height
Number of people living in child's home	
Who spends most time caring for child?	

Family Illness Record

Please mark an X if your child's blood relatives have had any of the following:	Father	Mother	Father's Side	Mother's Side	Sisters	Brothers
Alcohol or Drug Dep.						
Asthma						
Birth Defects						
Blood Disease						
Cancer						
Early Heart Attack						
Eye or Ear Disorder						
Juvenile Diabetes						
Kidney Disease						
Learning Disabilities						
Psychiatric Disability						
Serious Allergies						
Thyroid Disease						
High Blood Pressure						
High Cholesterol						