ONLY FILL OUT THIS SIDE OF THE ANNUAL FORM IF INSTRUCTED BY TODAY'S NURSE OR IF THERE HAS BEEN ANY CHANGE TO YOUR FAMILY HISTORY IN THE LAST YEAR

Does anyone in your family (1st and 2nd generation) have a history of: (Child's: Mother, Father, Grandparents, Aunts, Uncles, and 1st cousins)	Y	N	If yes, what illness and describe: Which family member, (indicate) Maternal or Paternal side of the family)
Food Allergies			
Asthma			
Childhood Hearing Loss			
Eye Disorders/Congenital Abnormalities/Retinoblastoma			
Epilepsy/Seizures			
Migraines or other Neurological Disorder			
Developmental Disabilities			
Autism/Cognitive Delay			
ADHD			
Immune Problems, HIV, Tuberculosis			
Thyroid Problems or other Endocrine disease			
Autoimmune Disease			
Anemia			
Genetic or Heritable Disease			
Orthopedic Disorders (example: Hip dysplasia, Scoliosis, Osteoporosis)			
Bleeding or Blood Disorder			
Stomach/Intestinal Problems			
Liver Disease			
Kidney Disease/Urologic Malformations			
Heart Abnormalities (congenital heart disease, valve abnormalities, Arrhythmias, hypertrophic cardiomyopathy, etc.)			Please Specify which Abnormality/Disease:
Hypertension/High Blood Pressure			
High Cholesterol or takes Cholesterol Medication			
Heart Attack (before age 60)			
Diabetes			
Cancer (before age 55)			
Depression			
Anxiety			
Eating Disorder			
Other Mental Illness			
Alcohol Abuse			
Substance/Drug Abuse			
Any other significant family history?			Please Specify: