



**Westwood Office**  
 541 High Street  
 Westwood, MA 02090  
 (781) 326-7700  
 Fax (781) 251-0910

**Mansfield Office**  
 454 Chauncy Street  
 Mansfield, MA 02048  
 (508) 339-9944  
 Fax (508) 452-3898

**Easton Office**  
 115 Main Street  
 Easton, MA 02356  
 (508) 535-5535  
 Fax (508) 238-1315

www.wmpeds.com

## Family History Form

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Siblings:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

On the following pages, please fill out as much information about each family member as possible. When listing any illnesses/diseases/conditions, please pay specific attention to the following:

- |   |   |
|---|---|
| Obesity   | Recurrent fainting                            |
| High blood pressure   | Learning disorders (ADHD, dyslexia)           |
| High cholesterol  | Depression or anxiety                         |
| Diabetes (type 1 or type 2)   | Bipolar disease (or schizophrenia)            |
| Heart attacks (please list age of first attack)                         | Drug or alcohol issues                        |
| Margfan's syndrome  | Smokers                                       |
| Other cardiac disease (rhythm disorders, murmurs, cardiomyopathy, etc.) | Deafness (under age 40)                       |
| Cysts on kidneys  | Infants/children with hip problems            |
| Other kidney disease  | Blindness                                     |
| Blood clots (including pulmonary embolism or other clotting disorders)  | Asthma  |
| Bleeding disorder (including Von Willebrand's)                          | Recurrent pneumonias or recurrent bronchitis  |
| Anemia (or thalesemia traits)   | Allergies (season or food)                    |
| History of having spleen removed  | Thyroid disease (hypothyroid or hyperthyroid) |
| Sudden Infant Death Syndrome (SIDS)                                     | Skin cancer (melanoma, basal cell)            |
| Auto accident/drowning death  | Colon cancer under age 50                     |
| Other unexplained deaths  | Kidney cancer under age 50                    |
| Tuberous sclerosis/neurofibromatosis                                    | Eye cancer (or eye removed)                   |
| Seizure problems  | Other cancers                                 |



**Westwood Office**  
541 High Street  
Westwood, MA 02090  
(781) 326-7700  
Fax (781) 251-0910

**Mansfield Office**  
454 Chauncy Street  
Mansfield, MA 02048  
(508) 339-9944  
Fax (508) 452-3898

**Easton Office**  
115 Main Street  
Easton, MA 02356  
(508) 535-5535  
Fax (508) 238-1315

[www.wmpeds.com](http://www.wmpeds.com)

**Family History Form: Fill in medical history of these relatives with names.**

Patient's Siblings	
Parent 1	
Parent 2	
Parent 1's Father (patients grandfather)	
Parent 1's Mother (patients grandmother)	
Parent 2's Father (patients grandfather)	
Parent 2's Mother (patients grandmother)	
Parent 1's Brothers (patients uncles)	
Parent 1's Sisters (patients aunts)	
Parent 2's Brothers (patients uncles)	
Parent 2's Sisters (patients aunts)	



**Boston Children's Hospital**  
Community of Care  
Preferred Pediatric Practice



**Westwood Office**  
 541 High Street  
 Westwood, MA 02090  
 (781) 326-7700  
 Fax (781) 251-0910

**Mansfield Office**  
 454 Chauncy Street  
 Mansfield, MA 02048  
 (508) 339-9944  
 Fax (508) 452-3898

**Easton Office**  
 115 Main Street  
 Easton, MA 02356  
 (508) 535-5535  
 Fax (508) 238-1315

www.wmpeds.com

Parents Marital Status			
Parent 1's Name & Occupation			
Parent 2's Name & Occupation			
Religion			
Do you have guns in your house?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a pool at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any smokers living in the house?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a fire extinguisher in your house?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a carbon monoxide detector in your house?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have pets? If yes, what type(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pets:
What type of heat do you have?	<input type="checkbox"/> Electric	<input type="checkbox"/> Gas	<input type="checkbox"/> Oil
What type of water do you have?	<input type="checkbox"/> Private Well	<input type="checkbox"/> Municipal (City/Town)	
Do you live in a house or apartment?	<input type="checkbox"/> House	<input type="checkbox"/> Apartment	