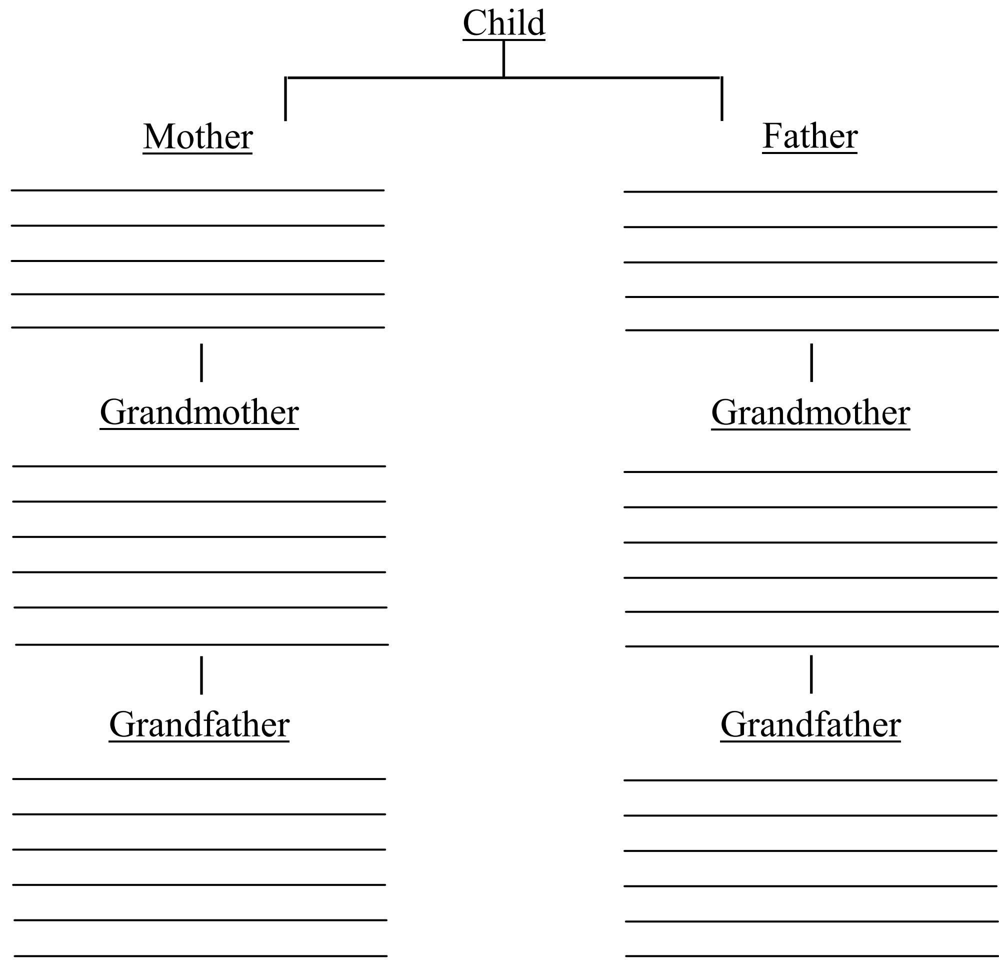
Cape Cod Pediatrics, LLP
Family History Form

Patient Name____________________
Date of Birth____________________
Today's Date____________________

Please indicate if the listed members of your child's family have or have had any of the following conditions:

Alcohol/Substance abuse	Diabetes	Liver disease
Allergies	Endocrine problems	Mental illness
Alzheimer's disease/Dementia	Epilepsy/Seizures	Obesity
Anemia	Headache/Migraines	Osteoporosis
Anxiety/Depression	Heart attack	Rheumatoid arthritis
Bleeding Disorder	Heart problems	Sleep Apnea
Coronary Artery Disease	High cholesterol	Thyroid problems
COPD	High blood pressure	Tuberculosis
Cancer	Immune problems	
Developmental disorder	Kidney disease	Other



Siblings

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Other
Please include relation and condition

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