Mercy Community Healthcare
Past Medical and Family History

Patient Name:_____

DOB:_____ **Date**:_____

Please mark an **"X"** in the appropriate illness for the patient and/or family member.	Patient	Father	Mother	Brother(s)	Sister(s)	Child(ren)	Mother's Side: Grandmother	Mother's Side: Grandfather	Father's Side: Grandmother	Father's Side: Grandfather
Cardiac										
Heart Attack										
High Blood Pressure										
High Cholesterol										
Other:_____										
Congenital/Genetic										
Genetic Diagnosis										
Premature Delivery										
Other:_____										
Developmental										
Developmental Delay										
Learning Disability										
Other:_____										
Digestive										
Gastroesophageal Reflux										
Crohn's Disease										
Diverticulitis										
Other:_____										
Urologic/Renal										
Kidney Disease										
Kidney Stones										
Urinary Tract Infection (UTI)										
Bladder Problems										
Other:_____										
Endocine/Hormone Disorders										
Diabetes Type I										
Diabetes Type II										
Hyperthyroidism										
Hypothyroidism										
Other:_____										

Please mark an **"X"** in the appropriate illness for the patient and/or family member.	Patient	Father	Mother	Brother(s)	Sister(s)	Child(ren)	Mother's Side: Grandmother	Mother's Side: Grandfather	Father's Side: Grandmother	Father's Side: Grandfather
Hematology										
Anemia										
Sickle Cell Disease										
Sickle Cell Trait										
Bleeding Disorder										
Other:_____										
Immunology										
Autoimmune Disorder										
Immune System Problems										
Other:_____										
Infectious Disease/Recurrent Infection										
RSV										
Chicken Pox										
Meningitis										
Recurrent Strep										
Staph Infection										
Other:_____										
Injury/Poisoning										
Poisonings										
Other injuries:_____										
Musculoskeletal										
Fractures										
Arthritis										
Muscle Disorders										
Other:_____										
Cancer/Neoplasm										
Breast										
Lung										
Skin										
Other:_____										
Ophthalmology										
Wears Glasses										
Lazy Eye										
Other:_____										
Neurologic Disorders										
Headaches/Migraines										
Seizures/Epilepsy										
Stroke										
Other:_____										

Please mark an **"X"** in the appropriate illness for the patient and/or family member.	Patient	Father	Mother	Brother(s)	Sister(s)	Child(ren)	Mother's Side: Grandmother	Mother's Side: Grandfather	Father's Side: Grandmother	Father's Side: Grandfather
Psychological Disorder										
Anxiety										
Depression										
Bipolar										
ADHD										
Suicidal Thoughts or Attempts										
Other:_____										
Respiratory Disorders										
Asthma										
Lung/Respiratory Disease										
Pneumonia										
Sinus Problems/Allergies										
Sleep Apnea										
Other:_____										
Skin Disorders										
Eczema										
Other:_____										
Surgical History										
Circumcision										
PE Tubes										
Tonsillectomy										
Other:_____										
Substance Use										
Smoker										
Alcohol Abuse										
Drug Abuse										
Other:_____										

Please list additional information regarding your child/family that has not been covered:

_____

_____

_____

_____

Patient Social History

Please list everyone who lives in the home:

_____

_____

_____

Is the patient adopted or living with a legal guardian other than birth parent(s)? **Yes** **No**