JDC Pediatrics
2025 Technology Parkway, Suite 2018 • Mechanicsburg, PA 17050

NEWBORN FAMILY HISTORY

CHILD'S NAME _____ Date of Birth _____
Last *First* *Middle*

Mother's Name _____ SSN _____
Last *First*

Father's Name _____ SSN _____
Last *First*

List all siblings living in the home _____

_____

Has a family member or contact had tuberculosis or a positive tuberculin skin test: ❑ Yes ❑ No

FAMILY HISTORY OF CHILD: Please indicate the child's blood relatives with the following problems using the abbreviations below:

M – Mother **S** – Sister **MGM** – Mother's Mother **PGM** – Father's Mother **A** – Aunt **C** – Cousin
F – Father **B** – Brother **MGF** – Mother's Father **PGF** – Father's Father **U** – Uncle

AIDS _____	Drug problems _____	Migraine _____
Allergies _____	Eye problems _____	Muscular disease _____
Alcohol problem _____	G.I. Disease _____	Neurological disease _____
Anemia _____	Hearing problems _____	Seizure _____
Asthma _____	Heart attack, age? _____	Skin problems _____
Arthritis _____	Heart disease _____	Sudden death, age? _____
Birth defects _____	High blood pressure _____	Thyroid disease _____
Blindness _____	High cholesterol _____	Tobacco use _____
Cancer, type? _____	Kidney disease _____	Tuberculosis _____
Cystic Fibrosis _____	Learning problems _____	Peptic ulcer _____
Deafness _____	Mental Illness _____	Other _____
Diabetes _____	Mental retardation _____	_____

❑ No Significant History

Are there pets in the home? ❑ No ❑ Yes If yes, please list types _____

Are guns kept in the home? ❑ No ❑ Yes If yes, are they securely locked away and inaccessible to children? ❑ Yes ❑ No

Are there additional issues not addressed above of which you would like to make JDC physicians aware? _____

_____

Signature of individual completing form: _____ Date: _____

POS Reorder # 1512294