**ADULT**
**FAMILY MEDICAL HISTORY**

Has anyone in your family had any of the following conditions? Check all that apply. Past or present.

| | My Mother | My Father | My Sibling | Mother's Relatives | Father's Relatives | My Children |
|---|---|---|---|---|---|---|
| ☐ Intellectual Disability | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Learning Problems | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Attention Problems | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Hyperactivity | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Seizures, epilepsy | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Neurologic disease | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Alcoholism | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Drug use or abuse | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Anxiety | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Depression | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Suicide | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Other Mental Health Problems: | | | | | | |
| Schizophrenia | _____ | _____ | _____ | _____ | _____ | _____ |
| Bi-polar Disorder | _____ | _____ | _____ | _____ | _____ | _____ |
| Autism | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Long term medical problems (e.g. asthma, diabetes, MS, CFS) | _____ | _____ | _____ | _____ | _____ | _____ |
| ☐ Other:_____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |