New England Pediatrics

ADHD EVALUATION
Family/Patient History

Date ___ /___ /___

PATIENT/CLIENT NAME

DATE OF BIRTH

LAST FIRST M D Y

In the space provided please indicate if your child or a close family member has or has had a history of:

Use this key to indicate relationship

M	Mother	PGM	Paternal Grandmother	MA/MU	Maternal Aunt/Uncle
F	Father	MGM	Maternal Grandmother	PA/PU	Paternal Aunt/Uncle
B	Brother	PGF	Paternal Grandfather	FC	First Cousin
S	Sister	MGF	Maternal Grandfather	P	Patient

	CHECK IF YES	RELATION
Congenital Heart Disease (CHD)	☐	______
Surgery to Correct CHD	☐	______
Heart Murmur	☐	______
Palpitations	☐	______
Fainting or Dizzy Spells	☐	______
Exercise Intolerence	☐	______
Irregular Heart Beat (any arrthythmia)	☐	______
Heart Attack / Death (before age 45)	☐	______
Stroke (before age 45)	☐	______
Unexplained Death (at young age)	☐	______
High Blood Pressure	☐	______
Thyroid Disease	☐	______

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