PRIMED PHYSICIANS

PEDIATRIC FAMILY HISTORY

Name _____

DOB _____ Sex _____

Date Reviewed/Initials: _____ _____

_____ _____ _____

_____ _____ _____

Dad's Name:_____ Date of Birth: _____

Mom's Name: _____Date of Birth: _____

Siblings: _____

Please circle "yes" if any of your child's close relatives (parents, grandparents, aunts, uncles, or siblings) have a history of any of these diseases. Explain any "yes" answers below.

1. Allergies yes
2. Anemia yes
3. Anesthesia Problems yes
4. Arthritis yes
5. Asthma/Lung Disease yes
6. Autism yes
7. Autoimmune Disorders (e.g.. Thyroid Disease) yes
8. Birth Defects (Hip Dysplasia, Congenital Heart Disease, Cleft Lip/Palate) yes
9. Bleeding or Clotting Problems yes
10. Cancer yes
11. Caregivers with immune compromise yes
12. Diabetes in Adults yes
13. Diabetes in Children yes
14. Epilepsy/Seizures yes
15. Eye Disease (Amblyopia, Lazy Eye) yes
16. Genetic or Inheritable Disease yes
17. Digestive Tract Disorders yes
(GERD, Colitis, Crohn's, Irritable Bowel , Celiac)
18. Heart Attack yes
(< 55 y.o. in men and < 65 y.o. in women)
19. High Blood Pressure yes
20. High Cholesterol yes
(<55 y.o. in men and < 65 y.o in women)
21. Learning Disability/School Failure/ADHD yes
22. Mental Retardation yes
23. Mental Health Disorder yes
(Depression, Anxiety, Eating Disorder, Substance Abuse)
24. Migraine yes
25. Stroke (< 55 y.o. in men and < 65 y.o. in women) yes
26. Sudden Death yes
27. Tuberculosis yes
28. Kidney Disease (Vesicoureteral Reflux, Stones) yes
29. Others yes

Explain any "yes" answers here. Tell us how your child is related to those who have the above illnesses. Please put the item number you are explaining

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