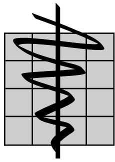

PriMed Physicians

Name ______________________

Address ______________________

Phone ______________________

Family History

Please complete this form and bring it to the first visit in the office. This form contains questions of a personal nature not directly regarding your child. If you are uncomfortable answering any of these questions, leave it blank and discuss it with one of the pediatricians.

This information does help us to understand the complete picture of your child's health. A copy of this form will be placed in each of your children's charts.

Who is living in the home including all children and adults?

Household Members

____

____

____

Family History of

Condition	Yes	No	*Who, in relation to your child or children, has this condition?*
Autoimmune disorder (eg. thyroid disease)	❑ Yes	❑ No	
Genetic or inheritable conditions not listed	❑ Yes	❑ No	
Learning disabilities/school failure	❑ Yes	❑ No	
Allergies	❑ Yes	❑ No	
Anesthesia problems	❑ Yes	❑ No	
Arthritis	❑ Yes	❑ No	
Asthma/Lung Disease	❑ Yes	❑ No	
Anemia (type?)	❑ Yes	❑ No	
Birth Defects	❑ Yes	❑ No	
Birth Deformities	❑ Yes	❑ No	
Bleeding Problems	❑ Yes	❑ No	
Cancer	❑ Yes	❑ No	
Cholesterol or Triglyceride elevations	❑ Yes	❑ No	
Diabetes (Adult)	❑ Yes	❑ No	
Diabetes (Childhood)	❑ Yes	❑ No	
Epilepsy, seizures	❑ Yes	❑ No	
Eye Diseases (Amblyopia)	❑ Yes	❑ No	
Heart Attack (age at 1st attack)	❑ Yes	❑ No	
Kidney Problems (stones, reflux)	❑ Yes	❑ No	
Mental Retardation	❑ Yes	❑ No	
Mental Health Disorder	❑ Yes	❑ No	
Stroke *(please note age at first stroke)*	❑ Yes	❑ No	
Tuberculosis	❑ Yes	❑ No	
Are there any smokers in your household	❑ Yes	❑ No	
Does anyone caring for the child have AIDS or any other immune problem?	❑ Yes	❑ No	
Is anyone caring for the child undergoing treatment for cancer?	❑ Yes	❑ No	
Does anyone caring for the child have problems with drugs or alcohol?	❑ Yes	❑ No	