

Ambler Pediatrics
Family History Questionnaire

(please circle)

Patient's Name _____

Date of Birth _____ M F

Are there any physical limitations with any of the following?

	Patient	Parent/Guardian	Please explain:
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Emotional	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spiritual/Cultural	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Spoken Language:	<input type="checkbox"/> English	<input type="checkbox"/> English	<input type="checkbox"/> Other: _____

Household

Please list all those living in the child's home

First and last name	Relationship to child	Date of Birth

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If there are any pets in the home, please indicate below:

If one or both parents are not living in the home, how often does he/she see the parent(s) not in the home? _____

Family History

Have any family members including parents, grandparents, & sibs had the following:

Hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Heart disease (before 50 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
High blood pressure (before 50 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Weight issues—Overweight/ Underweight	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Bleeding disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____

Elevated Lead level	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Family History (cont'd)				
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Diabetes (before 50 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Bed-wetting (after 10 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Epilepsy or seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Cigarette smokers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Mental retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Attention Deficit Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Learning disabilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____
Immune problems, HIV or AIDS <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Explain _____

Additional history _____

Questionnaire completed by: _____ Relationship to patient: _____
 (please print)

By signing below, I certify that the above information I have provided is true and accurate to the best of my knowledge.

Signature: _____ Today's Date: _____