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	□Yes □No	□Yes □No	
Hearing	□Yes □No	□Yes □No	
Physical	□Yes □No	□Yes □No	
Learning	□Yes □No	□Yes □No	
Emotional	□Yes □No	□Yes □No	
Spiritual/Cultural	□Yes □No	□Yes □No	
Primary Spoken Language:	□English	□English	□Other:_________________

Household

Please list all those living in the child's home

First and last name	Relationship to child	Date of Birth

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

____

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

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

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

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Family History

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

Hearing loss	□ Yes	□ No	Who _____	Explain ___________________________
Nasal allergies	□ Yes	□ No	Who _____	Explain ___________________________
Asthma	□ Yes	□ No	Who _____	Explain ___________________________
Tuberculosis	□ Yes	□ No	Who _____	Explain ___________________________
Heart disease (before 50 yrs old)	□ Yes	□ No	Who _____	Explain ___________________________
High blood pressure (before 50 yrs old)	□ Yes	□ No	Who _____	Explain ___________________________
High cholesterol	□ Yes	□ No	Who _____	Explain ___________________________
Weight issues—Overweight/ Underweight	□ Yes	□ No	Who _____	Explain ___________________________
Anemia	□ Yes	□ No	Who _____	Explain ___________________________
Bleeding disorder	□ Yes	□ No	Who _____	Explain ___________________________

(----OVER----- SIDE 2-----)

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

Additional history ____

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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:** _____________________