PREMIER MEDICAL ASSOCIATES

PEDIATRIC FAMILY HISTORY INFORMATION

Date: _____ Patient's Name: _____

Date of Birth: _____ Sex: _____ Race: _____

Father's Name: _____ Age: _____ Religion: _____

Occupation: _____

Mother's Name: _____ Age: _____ Religion: _____

Occupation: _____ Year: Married: _____

PATIENT'S BIRTH HISTORY

Birth Weight: _____ Delivery: Vaginal _____ or C-Section _____

Hospital: _____ Obstetrician: _____

Is there a history of the following illnesses in your ***EXTENDED*** family:

	YES	NO
Allergies	☐	☐
Asthma	☐	☐
Hayfever	☐	☐
Milk or Food Products	☐	☐
Coronary Artery Disease	☐	☐
Heart Attacks or Strokes before Age 60	☐	☐
Heart Attack or Death During Sports	☐	☐
High Blood Pressure	☐	☐
High Blood Fats or Cholesterol	☐	☐
Bypass Surgery	☐	☐
Angina	☐	☐
Stomach, Intestine or Bowel Problems	☐	☐
Colitis	☐	☐
Nerve or Brain Disease	☐	☐
Psychiatric Disorder	☐	☐
Mental Retardation	☐	☐
Depression	☐	☐
Suicide	☐	☐
Alcoholism	☐	☐
Seizures	☐	☐
Migraine Headaches	☐	☐
Delays in Growth or Development	☐	☐

	YES	NO
Lung Disease	☐	☐
Smokers at Home or in Family	☐	☐
Emphysema	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Kidney Disease	☐	☐
Urine Infections	☐	☐
AIDS/HIV Positive	☐	☐
Anemia	☐	☐
Bleeding Too Much	☐	☐
Bruising Too Easily	☐	☐
Sickle Cell Disease	☐	☐
Birth Defects	☐	☐
Bone Disease	☐	☐
Cancer or Leukemia	☐	☐
Frequent Infections	☐	☐
Hearing Difficulties or Deafness	☐	☐
Muscle Problems	☐	☐
Skin Problems	☐	☐
T.B. (Tuberculosis)	☐	☐
Visual Problems (other than glasses)	☐	☐

(Complete other side for patients older than 4 months)

TO BE COMPLETED FOR ALL NEW PATIENTS OLDER THAN 4 MONTHS:

Has your child ever had any of the following:

1) Surgery? _____

2) Hospitalizations? _____

3) Allergic reactions to medications? _____

4) Allergic reactions to food? _____

5) Recurrent medical problems (e.g. ear infections) _____

_____

6) Seizures? _____

7) Significant reaction to immunizations? _____

8) Prematurity? _____