AUSTINTOWN PEDIATRICS INC.

107 JAVIT COURT
YOUNGSTOWN, OH 44515
(330) 797-0407 FAX: (330) 793-1431

Complete following information about your Child

FAMILY HISTORY QUESTIONNAIRE

Infant's Name_____ **Today's Date**_____
Drug Allergies_____ **Date of Birth**_____
Reaction:_____

Current Medications **Dosage** **Times/Day**

_____

_____

Family History:

Have any blood relatives (**child's sibling, parent or grandparents, 1st cousin**) had any of the following:
*Please indicate Maternal or Paternal side of family also.

			Relationship				**Relationship**
Allergies	Y	N	_____	Heart Disease	Y	N	_____
Anemia	Y	N	_____	Heart Attack (<40y/o)	Y	N	_____
Asthma	Y	N	_____	High Blood Pressure	Y	N	_____
Bleeding Disorder	Y	N	_____	High Cholesterol	Y	N	_____
Cancer	Y	N	_____	Stroke	Y	N	_____
Diabetes	Y	N	_____	Thyroid Disease	Y	N	_____
Epilepsy (seizures)	Y	N	_____	Tuberculosis	Y	N	_____
Any Other Disease	Y	N (please list)		Mental Illness	Y	N	_____

_____

_____

Social History:

Child's home: House/apartment/trailer/other _____ (circle one)
Approximate year home built _____ (if known)
Who lives with child? Mom Y N
Dad Y N
Is noncustodial parent involved? Y N
List others in home _____
Pets/animals in home Y N Type _____
Guns in home Y N
Smoke in home/outside/car (circle all that apply) Packs per day _____
Alcohol Y N Drinks per week _____
Caffeine Y N Cups per day _____
Illegal drugs Y N Type: _____ Frequency: _____/week/day

Office use only:
_____
_____
_____
_____
_____