AMHERST PEDIATRIC ASSOCIATES
FAMILY MEDICAL HISTORY

Please fill in the following medical history record. Only information pertaining to the parents, siblings, and grandparents of your child/children is necessary.

YES	NO		DETAILS/RELATIONSHIP TO CHILD
☐	☐	Congenital Hearing Loss	______________________________
☐	☐	Mental Retardation	______________________________
☐	☐	Food Allergies/Hay Fever	______________________________
☐	☐	Asthma	______________________________
☐	☐	High Blood Pressure	______________________________
☐	☐	Heart/Valve Trouble	______________________________
☐	☐	Coronary Artery Disease	______________________________
☐	☐	Stroke	______________________________
☐	☐	Alcoholism	______________________________
☐	☐	Diabetes	______________________________
☐	☐	Cancer	______________________________
☐	☐	Cigarette Smoking	______________________________
☐	☐	High Cholesterol	______________________________
☐	☐	Anemia/Blood Disorders	______________________________
☐	☐	Hemophilia	______________________________
☐	☐	Kidney Problems	______________________________
☐	☐	Obesity	______________________________

Any other family history information: ____

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Pets: ____

Guarantee of account and acceptance conditions: I authorize and direct Amherst Pediatric Associates, having treated my child(ren), to release to governmental agencies, insurance carriers, and others who are financially liable for medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby sign, transfer, and set over to Amherst Pediatric Associates sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for medical care or cover the costs of care and treatment rendered to my children. I hereby agree that in consideration of the service rendered to my children, I shall pay the account of Amherst Pediatric Associates in accordance with the rates and terms of these agencies for services rendered.

Signature: ____ Date: ______________