Social History

Mother's Name: _____ Occupation _____ DOB: _____

Father's Name: _____ Occupation _____ DOB: _____

Siblings: Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Marital Status of parents: _____

Child lives with: _____

Are there any family circumstances we should know about? _____

Smokers in house? Yes ◯ No ◯ Who? _____

Firearms in house? Yes ◯ No ◯

Smoke detectors in the house? Yes ◯ No ◯

Pets (Describe): _____

Religious Preference: _____

Family History

Please describe any health conditions in your family. Please include the child's parents, brothers, sisters, grandparents (maternal and paternal), aunts and uncles. (check the condition and identify who has the condition in the blank space to the right).

Problems	No Problems		Who	What
◯	◯	Constitutional (Unexplained ill feelings, unexplained fevers, unexplained weight loss, Cancer, Leukemia, High Cholesterol)	_____ :	_____
◯	◯	Eyes (Cataracts, Cross Eyes)	_____ :	_____
◯	◯	Ears, Nose, Mouth and Throat (Chronic Ear or Sinus Infections)	_____ :	_____
◯	◯	Heart or Blood Vessels (Hole in Heart, Murmur, High Blood Pressure, Heart Attack)	_____ :	_____
◯	◯	Breathing or Lung Disease (Asthma, Bronchitis, CF, other lung disease)	_____ :	_____
◯	◯	Stomach, Intestinal Tract (Chronic Diarrhea, Constipation, Digestion, Ulcer, Intestinal or Bowel Problems)	_____ :	_____
◯	◯	Joints, Muscles, Extremities	_____ :	_____
◯	◯	Skin	_____ :	_____
◯	◯	Neurological System (ADAD, LD, Mental Retardation, CP, Seizures, Stroke, Alzheimer's)	_____ :	_____
◯	◯	Psychological or Mental Health (Depression or Anxiety)	_____ :	_____
◯	◯	Endocrine (Glandular Problems, Diabetes, Thyroid Disease)	_____ :	_____
◯	◯	Blood Disease (SCA, Sickle Trait)	_____ :	_____
◯	◯	Immunology (Chronic Allergies, Weak Immune System)	_____ :	_____
◯	◯	Bladder & Kidney (Chronic Bladder Infections, Kidney Failure)	_____ :	_____

First Time Provider Reviewed: _____ Date: _____

Reviewed: _____ _____

_____ _____