

## SOCIAL HISTORY

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_

Siblings: Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

Marital Status of parents: \_\_\_\_\_ Child lives with: \_\_\_\_\_

List any family circumstances we should know about: \_\_\_\_\_

Smokers in family?  Yes  No Who? \_\_\_\_\_

Firearms in the house?  Yes  No Who? \_\_\_\_\_

Pets in the house?  Yes  No Describe: \_\_\_\_\_

Smoke detectors in the house?  Yes  No Religious Preference: \_\_\_\_\_

## FAMILY HISTORY

*Family includes: the child's parents, brothers, sisters, grandparents (maternal & paternal), aunts & uncles.*

*Please check "Problems or "No Problems". If there is a problem, fill out who has the condition and what the condition is.*

Problems	No Problems	Who	What Condition
			Constitutional (unexplained ill feelings, fevers, weight loss, Cancer, Leukemia, High Cholesterol)
			Eyes (Cataracts, Cross Eyes)
			Ears, Nose, Mouth & Throat (Chronic Ear or Sinus Infections)
			Heart & Blood Vessels (Hold 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 issues
			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)

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_