FAMILY HISTORY

Patient Name:_____ DOB:_____ Phone #:_____

Father: Date of Birth:_____ **Mother: Date of Birth**:_____

Health:_____ **Health**:_____

Grandparent's Health:_____ **Grandparent's Health**:_____

_____ _____

CHRONIC DISEASES	**YES**	**NO**	**If Yes, how related to the child(ren)?**
Allergy/Asthma			
Anemia or Blood Disorders			
Cancer			
Colitis/Stomach Disorders			
Convulsions/Seizure Disorders			
Deafness/Blindness (specify)			
Depression or Psychiatric Disorders			
Diabetes			
Heart Disease			
Inherited Disorders			
Mentally Retarded Children			
Skin Conditions			
Tuberculosis			

Social History: Who lives in your house?_____

_____

Primary Language spoken at home_____

Nearest friend or relative not living with you:
Name_____ Phone#_____
Address_____
Relationship_____

Does anyone in the household smoke? (circle one) yes no

Do you have a fireplace or wood burning stove? (circle one) yes no

Does child attend any of the following? (circle all that pertain)

Child Care Public School Private School College Other_____

Date completed:_____
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