Child's Name: _____ Date of Birth: _____

Family History

(Parents, Grandparents, and Siblings)

Please check all that apply and specify which family member

☐ Alcoholism _____
☐ Arthritis _____
☐ Asthma _____
☐ Bleeding Disorder _____
☐ Breast Cancer _____
☐ Cervical Cancer _____
☐ Coronary Artery Disease _____
☐ Coronary Artery Dis. Male < 55 _____
☐ Coronary Artery Dis. Female < 65 _____
☐ Colon Cancer _____
☐ Colon Polyps _____
☐ Depression _____
☐ Diabetes _____
☐ CVA or Stroke _____
☐ Hypertension (High Blood Pressure) _____
☐ Hyperlipidemia (High Cholesterol) _____
☐ Lung Cancer _____
☐ Melanoma _____
☐ Migraine _____
☐ Osteoporosis _____
☐ Ovarian Cancer _____
☐ Pancreatic Cancer _____
☐ Prostate Cancer _____
☐ Renal Disease _____
☐ Seizures _____
☐ Skin Cancer _____
☐ Suicide _____
☐ Thyroid Disease _____
☐ Huntington's Disease _____
☐ Learning Disabilities _____
☐ ADD _____
☐ ADHD _____

Social History of Child

Please check yes or no:

Y N

☐☐ History of Domestic Abuse
☐☐ Religion Affecting Care
☐☐ Foster Care
☐☐ Parents Divorced
☐☐ Lives with Grandparents
☐☐ Adopted
☐☐ Exposed to Smoke
☐☐ Immunizations Up to Date

Please fill in the following answers:

Parents or Guardians Names:

_____

Step Parents Names (if applicable):

_____

_____

Siblings Names: _____

_____

School: _____

Allergies: _____

Ethnicity: _____

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____ Date: _____