Pediatric Family & Social History Form

Patient Name: ____________________

Birthday: ____________________

Today's Date: ___/___/20___

Chart Number:

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Entered By:________________ Reviewed by: ____________________

FAMILY HISTORY: Please indicate with a check (✓) relatives with any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Allergies												
Anemia												
Asthma												
Bleeding problems												
Cancer (what type)												
Congenital Anomaly/Birth Defect												
Depression												
Diabetes												
Eczema												
Food Allergies (which foods)												
Hearing Disorder												
Heart Attack/Heart Disease												
High cholesterol												
High blood pressure												
Kidney Disease												
Learning Disability												
Mental illness												
Obesity												
Seizures												
Stroke												
Thyroid Disorder												
Tuberculosis												
Drug abuse												
Smoke tobacco												
Chew tobacco												
Death before age 56												
Other:												

SOCIAL HISTORY: Please indicate with a check (✓) for the patient:

RACIAL GROUPS:

White	
American Indian	
Asian	
Black or African American	
Pacific Islander/ Native Hawaiian	
Other	
Refuse to Answer	

HISPANIC ETHNICITY:

Hispanic or Latino	
Not Hispanic or Latino	
Refuse to Answer	

PREFERRED LANGUAGE:

English	
Spanish	
Other: ______________	
Refuse to Answer	

SMOKING STATUS:

Never Smoked	
Smoker	
Ex-Smoker	
Experimental Smoker	
Packs per day	
Use Chewing Tobacco	
Never Chewed Tobacco	
Refuse to Answer	

How long have you been a Smoker? ____________

When did you QUIT? ____________

How much Chewing Tobacco per day?

MEDICAL HISTORY:

Please Hospitalization	Date	Hospital	Doctor	Diagnosis

Please list all Surgeries	Date	Hospital	Doctor	Reason

Please answer the following questions:

Please indicate your child's Blood Type: ___A+ ___A- ___B+ ___B- ___AB+ ___AB- ___O+ ___O- ___Don't Know

Has your child ever had a Blood Transfusion? ___yes ___no

Date: ______________ Reason: ______________

Has your child ever had a Chest X-ray? ___yes ___no

Date: ______________ Status: ______________

Date: ______________ Status: ______________

Date: ______________ Status: ______________

Has your child ever had a TB Skin Test? ___yes ___no

Date: ______________ Status: ______________

Date: ______________ Status: ______________

Date: ______________ Status: ______________