Patient's Full Legal Name: (Last, First, Middle)

____ DOB: _______

Family History

Today's Date:

Family Social History

Fill in and Check appropriate boxes:	Occupation	Employer	Daycare	Year in School	GED	HS Diploma	Trade/Vocational	Associate Degree	Bachelor's Degree	Post Graduate
Patient			Yes No							
Mother										
Father										
Guardian										

Home and Family Environment

Parental Marital Status:. *Circle* : Married Divorced Separated Single Widowed Other: __________________________

Household Members. *Circle all that apply:* **Mother Father Stepmother Stepfather Grandparents Guardian Siblings Others:** __________________

Siblings	DOB (MM/YY)	Gender	Siblings	DOB(MM/YY)	Gender
1.		Male Female	**4.**		Male Female
2.		Male Female	**5.**		Male Female
3.		Male Female	**6.**		Male Female

Are there pets in the home?	Yes	No	**Does your pool have a fence?**	Yes	No
Is a seatbelt/carseat used consistently?	' es	No	**Is there smoking in the home?**	Yes	No
Is sunscreen used consistently?	' es	No	**Are there guns in the home?**	Yes	No

Family Medical History

Check the appropriate boxes:	Alive	Deceased	ADHD	Anemia	Asthma	Bleeding/ Clotting issues	Blood Pressure	Cancer	Deafness	Diabetes	GI Problems	Headaches	Heart Disease	High Cholesterol	Immune/ Infectious Diseases	Kidney Problems	Mental Health	Seizures	Thyroid Disease	Other Medical History
Mother	A	D																		
Father	A	D																		
Sister(s)	A	D																		
Brother(s)	A	D																		
Maternal Grandparent	A	D																		
Paternal Grandparent	A	D																		
Maternal Aunt/Uncle	A	D																		
Paternal/Aun/Uncle	A	D																		
Cousin(s)	A	D																		

Thank you for choosing Pediatric Partners