Family / Social History Questionnair e

To be filled out by parent

Patient's name________________________
Date of birth_________________________

Date of Entry________________________
Source of information________________

Family History

Has anyone in your family (Parents, grandparents, siblings, cousins, etc) had any of the following problems under the age of 55 years:

Heart Disease/Stroke?	Y	N
High Blood Pressure?	Y	N
High Cholesterol?	Y	N
Diabetes?	Y	N
Stomach / Intestine Problems?	Y	N
Arthritis?	Y	N
Thyroid Disease?	Y	N
Mental Illness?	Y	N
Mental Retardation?	Y	N
Birth Defects?	Y	N
Hearing / Speech Problems?	Y	N
Learning Problems?	Y	N
Lead Poisoning?	Y	N
Asthma / Lung Disease?	Y	N
Allergies?	Y	N
Seizures / Neurologic Problems?	Y	N
Cancer?	Y	N
Kidney Disease?	Y	N
Urinary Problems?	Y	N
Hepatitis / Liver Disease?	Y	N
Attention Deficit Disorder?	Y	N
Hemophilia / Sickle Cell?	Y	N
Vision problems?	Y	N
Other? (please specify)	Y	N

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Social / Environmental History

Does your child have regular contact with anyone who has had the following:

Immune Problems?	Y	N
Tuberculosis?	Y	N
HIV / AIDS?	Y	N
Chronic Steroid Treatments?	Y	N
Chemo / Radiation Therapy?	Y	N
Advanced Chronic Diseases?	Y	N
Alcohol / Drug Abuse?	Y	N
Family Violence?	Y	N

Other? (please specify) _____________________
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Is your child / children in daycare or other arrangement? (please specify)________________
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Any smokers?	Y	N
Any pets?	Y	N
Any guns in the home?	Y	N
Does your child live in or regularly visit a house built before 1960 with peeling or chipping paint?	Y	N
Do you have working smoke alarms?	Y	N
Do you have well water?	Y	N