

Family and Social History Questionnaire

Patient _____ Date of Birth: _____ Email _____

Parent/Guardian Information (please list in the Parent 1 and 2 lines below, circle relationship)

Parent 1 _____

Biologic
Mother Father

Adoptive
Mother Father

 Other: _____
 Phone: _____ Legal Guardian: Y N Occupation: _____
 Cell phone: _____ Married, Divorced, Single, Widowed
 Email _____

Parent 2 _____

Biologic
Mother Father

Adoptive
Mother Father

 Other: _____
 Phone: _____ Legal Guardian: Y N Occupation: _____
 Cell phone: _____ Married, Divorced, Single, Widowed
 Email _____

Legal Guardian (if not parent): Name _____ Relationship _____ Cell phone: _____
 Email _____

Emergency Contact _____ Phone _____ Relationship _____

Please mark all that apply

	Yes	No	List
Pregnancy or Birth complications			
Allergies to Foods			
Previous Hospitalizations			
Previous Surgeries			
Any smokers in the home			
Other past medical history			

Names of other children in family

Name _____ Date of Birth _____ Sex _____
 Name _____ Date of Birth _____ Sex _____
 Name _____ Date of Birth _____ Sex _____
 Name _____ Date of Birth _____ Sex _____

Is there a family history of any of the following diseases (check if yes)

- | | |
|-----------------------------------|---------------------------|
| _____ Attention Deficit Disorder | _____ Heart Disease |
| _____ Alcoholism | _____ High Cholesterol |
| _____ Allergies | _____ High Blood Pressure |
| _____ Arthritis | _____ Lung Disease |
| _____ Asthma | _____ Mental Illness |
| _____ Bleeding/Clotting | _____ Migraine |
| _____ Cancer | _____ Neurological |
| _____ Depression | _____ Seizures |
| _____ Diabetes | _____ Smoking |
| _____ Drug Abuse | _____ Strokes |
| _____ Eczema | _____ Sudden Death |
| _____ Hay Fever | _____ Weight Problems |
| _____ Heart attacks before age 50 | |

MRN _____
 Office use only

