



PEDIATRIC SOCIAL HISTORY

Patient Name _____
Last First Middle

Lives at home with _____ Both Parents _____ Mom _____ Dad _____ Other

Smokers in house _____ Yes _____ No

Are there any Firearms in the house? _____ Yes _____ No

Do you have a Pool? _____ Yes _____ No

How often does your child exercise? _____ None _____ 1 -3 days _____ 5 – 7 days

Home smoke detector use? _____ Yes _____ No

How much caffeine daily? _____ None _____ 1-2 cups _____ 3-4 cups _____ 5 or more

School _____ Public _____ Private _____ Home School

Grade Level _____ Pre-School _____ Elementary _____ Middle _____ High School

Performance _____ A's _____ B's _____ C's _____ D's _____ Failing

Daycare _____ Yes _____ No

Pets _____ Yes _____ No

Immunizations up to date _____ Yes _____ No

School Attended _____

Allergies (Medications or Substance) _____

Current Medications _____

**** PLEASE PROVIDE CURRENT IMMUNIZATIONS RECORDS FOR YOUR CHILD.**