CENTRE PEDIATRIC ASSOCIATES, P.C. FAMILY HISTORY SUMMARY

Child's Name: **Child's Date of Birth:**

Family History: Please indicate with an **(X)** family members who have had any of the following conditions:

Illness/Disease	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Anxiety								
Asthma								
Autoimmune Disorder								
Bleeding Disorders								
Cancer: Please specify type________________________								
Cancer: Please specify type________________________								
Celiac Disease								
Congenital Hip Disorder								
Depression								
Diabetes Type I (childhood onset)								
Diabetes Type 2 (adult onset)								
Genetic Disorder								
Hearing Disorder								
Heart Attack/Coronary Artery Disease								
High Cholesterol (Hyperlipidemia)								
High Blood Pressure (Hypertension)								
Hypercoagulation Disorder or blood clots								
Kidney Disease								
Psychiatric/Mental Illness								
Seizure Disorder								
Thyroid Disorder								
Ulcerative Colitis/Crohn's Disease								
Death before age 56 for reasons not stated above								
Other:____								
Other:____								

SOCIAL HISTORY: Please list patient's family and household members:

Name	Age	Relationship	Occupation/Employer	Cell Phone No.

Is violence at home a concern? □Yes □No

Are there guns in the home? □Yes □ No

Do any family members smoke? □ Yes □No

Are there pets at home? □Yes □No