



Pediatric Associates of Brockton

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FAMILY HISTORY

Patient Name: _____ DOB: _____ Phone #: _____

Father: Date of Birth: _____ Mother: Date of Birth: _____

Health: _____ Health: _____

Grandparent's Health: _____ Grandparent's Health: _____

CHRONIC DISEASES YES NO If Yes, how related to the child(ren)?

Allergy/Asthma			
Anemia or Blood Disorders			
Cancer (type)			
Colitis/Stomach Disorders			
Convulsions/Seizure Disorders			
Deafness/Blindness (specify)			
Depression or Psychiatric Disorders			
Diabetes			
Heart Disease			
Inherited Disorders			
Intellectual Disability / Neurodevelopment Disorder			
Skin Conditions			
Tuberculosis			

Social History: Who lives in your house? _____

Primary Language spoken at home _____

Nearest friend or relative not living with you:

Name _____ Phone# _____

Address _____

Relationship _____

Does anyone in the household smoke? (circle one) yes no

Do you have a fireplace or wood burning stove? (circle one) yes no

Does child attend any of the following? (circle all that pertain)

Child Care Public School Private School College Other _____

Date completed: _____