

## SCHWARTZ PEDIATRICS

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**ETHNICITY:**

**CHECK MOST APPROPRIATE**

CAUCASIAN

AFRICAN AMERICAN

OTHER

HISPANIC

ASIAN

\_\_\_\_\_

**FAMILY HISTORY:**

**CHECK THE DISEASES THAT AFFECT FAMILY MEMBERS UNDER THE AGE OF 50**

ADD

DEPRESSION

HYPERTENSION

ALCOHOL ABUSE

DIABETES MELLITUS

KIDNEY DISEASE

ASTHMA

DRUG ABUSE

SEIZURES

CANCER

HEART DISEASE

SIDS

CYSTIC FIBROSIS

HEMOPHILIA

THYROID DISEASE

OTHER

**SOCIAL HISTORY:**

**CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS**

CHILD BREASTFED?

YES

NO

SMOKERS IN THE HOUSE?

YES

NO

CATS IN THE HOUSE?

YES

NO

DOGS IN THE HOUSE?

YES

NO

CHILD IN DAY CARE?

YES

NO

PARENTS DIVORCED?

YES

NO

PARENTS SEPARATED?

YES

NO

**IMMUNIZATION HISTORY:**

**THE OFFICE MUST HAVE A COPY OF YOUR CHILD'S VACCINE RECORD TO ASSURE OPTIMAL CARE**