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**Initial Past, Social, and Family History**

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Past Medical History:**

Medical Problems:

Medications:

Allergies:

Hospitalizations:

Surgeries:

**Family History:**

**Social History:**

Any smokers at home or around patient? Yes or No who? \_\_\_\_\_

Any pets at home? Yes or No what kind? \_\_\_\_\_

Does your child attend school or daycare? Yes or No

Who else lives in the same household?

\_\_\_\_\_  
 Sign

\_\_\_\_\_  
 Date