Welcome To
Kennesaw Pediatrics
Your Home for Pediatric Healthcare!

3745 Cherokee Street, Suite 401
Kennesaw, GA 30144
770 – 429-1005 – Phone
770-429-8005 Fax
www.kennesawpediatrics.com – Web
info@kennesawpediatrics.com – Email

Patient(s) Family History

Information about your child(ren):

Full Name _____ DOB: _____ Gender: M F

Mother:

Full Name _____ DOB: _____ Height: _____ Weight: _____

Medical Problem(s): _____ Education Level: _____

Father:

Full Name _____ DOB: _____ Height: _____ Weight: _____

Medical Problem(s): _____ Education Level: _____

Is there a family history (including child's parents, siblings, grandparents, aunts, uncles) of any of the following?

Please circle YES or NO to all questions:

Allergies	YES NO	Early Heart Attacks	YES NO	Kidney Disease	YES NO
Asthma/Wheezing	YES NO	Emotional Problems	YES NO	Mental Problems	YES NO
Birth Defects	YES NO	Epilepsy	YES NO	Thyroid Disease	YES NO
Bleeding Tendencies	YES NO	High Blood Pressure	YES NO	Tuberculosis	YES NO
Convulsions	YES NO	High Cholesterol	YES NO	Lazy Eye	YES NO
Diabetes	YES NO	Hip Disorders in Infancy	YES NO	Other Heart Disease	YES NO
				Other Illnesses	YES NO

If you answered YES to any of the above, please explain:

_____

Social History:

Do you and your family have a religious preference? YES NO If yes, please specify _____

Marital Status of parents: Married Single

Has there been a separation, divorce, or death? Specify: _____

What has been the attitude of your child to this situation? _____

Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, acupuncture or herbal medicine? YES NO If yes, please specify: _____

Is there a gun in your home? YES NO

Are there pets in your home? YES NO

Does anyone in your home smoke? YES NO

Are there any financial problems in the family? YES NO

Are there family disagreements on how to raise the child(ren)? YES NO

List all family members child(ren) live with: _____

Name of person completing the form: _____ Relation to patient: _____

Signature: _____ **Patient Name:** _____ **Date:** _____