

Social History

FORM 106 - R180917

Patient Name _____ Date of Birth _____

Hobbies/Activities _____

Does patient follow a special diet or have any food allergies? no yes _____

Does patient attend school? no yes School Name _____ Grade _____

Does patient have any physical disabilities, learning disabilities or special needs? no yes _____

Does patient work? no yes Hours per week _____

DOES PATIENT'S HOUSEHOLD HAVE...

	Yes	No	Unsure
Well water			
Exposure to lead			
Exposure to tobacco			
Smoke detectors			
Carbon monoxide detectors			

THIS INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signed by _____ Date _____

Print Name _____ Relationship _____

SPC ONLY

PCP _____

R _____ D _____



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