FLINT
FAMILY HEALTHCARE
4 N. MAIN STREET
MAYSVILLE, GA 30558

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Family Structure Survey

Patient Name:

_____DOB:_____Appt. Date: _____

Home Environment

Who does this child live with? What is this person's relation to the child?

How many other children live in the home? _____

Medical History

Does this patient have current or previous injuries to report? Please list all below.

Has this patient had any surgeries or hospitalizations? Please list all below.

Family Background

Mom ☐ Alive ☐ Passed Away ☐ Unknown	Dad ☐ Alive ☐ Passed Away ☐ Unknown

Social History

Does this child attend daycare? ___ Yes ____ No If yes, how often?_____

Any exposure to smoking? _____Yes _____No

Please answer the following for a child over 11 years of age:

Alcohol use	_____ Yes _____No	Drug Use	_____ Yes _____No	Caffeine use	____Yes ____No
Employment:	***___Employed***	***____Unemployed***		***____Student***	
Are you sexually active: _____Yes _____No					