Intellectual Property of Rau Family Medicine RFM006
380 Plaza Drive, Suite D
Columbus, IN 47201

RAU FAMILY MEDICINE

Date: ______________

PATIENT SOCIAL HISTORY

Parents: Have you signed our minor consent form for your children? ❑ yes ❑ no Initials _____

Name: ______________________ **DOB:** __________ **Soc. Sec. #:** __________
Address: ______________________ **City:** __________ **State:** ______ **Zip:** __________
Spouse (parent) name: ______________________ **Employment:** __________
In case of emergency contact: ______________________ Phone #: __________

Birth History: ❑ vaginal delivery ❑ c-section Complications: ______________________
Where were you born? __________ Obstetrician: __________ Pediatrician: __________

Marital Status:
❑ Single; Significant other? ❑ yes ❑ no; If yes: Name of significant other: __________
❑ Married #1 Date__________; #2 Date__________; #3 Date__________.
❑ Divorced #1 Date__________; #2 Date__________; #3 Date__________.
❑ Widowed #1 Date__________; #2 Date__________; #3 Date__________.

Religion/Church Affiliations: ______________________

Education: Did you attend pre-school?: ❑ yes ❑ no What is the highest level of education you have completed?
❑ some high school ❑ high school graduate ❑ college or technical degree ❑ post graduate college
Last School attended______________________

Military: ______________________ **Stationed:** ______________________

- Please list employment in chronological order starting with your current/most recent employment.

Note: For those under 18 yrs. include parents occupations. Designate mother = M, father = F.

Employment	Start	End	Job Description	Health / Safety Risks
1.				
2.				
3.				

Insurance: Primary; ______________________ **Secondary;** ______________________
Deductible: ______________________ **Co-insurance / Co-payment:** __________
Network Limitation: ❑ yes ❑ no **Point of Service Agreement:** ❑ yes ❑ no

Community / School Activities: ______________________

____

Any recent situational stressors or major life changes?: ______________________

____

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Children Name	Sex	DOB	Relationship*	Functional Status*	If D why?
1.					
2.					
3.					
4.					
5.					

* Relationship: Biological = B, Adopted = A, Step Child = S, Half Sibling = H.
Functional Status: Dependent = D, Independent = I.

Sibling Name	Sex	DOB	Relationship*	Functional Status*	If D why?
1.					
2.					
3.					
4.					
5.					

* Relationship: Biological = B, Adopted = A, Step Child = S, Half Sibling = H.
Functional Status: Dependent = D, Independent = I.

Parents: Are they?: ❑ never married ❑ married Date:_______ ❑ divorced Date:_______ ❑ remarried / father Date:_______ ❑ remarried / mother Date:________

Are they ❑ dependent or ❑ independent? If dependent, why? ____________________

Do you have grandparents living? ❑yes ❑ no

If yes, are they ❑ dependent or ❑ independent? If dependent, why? ____________________

Do you have grandchildren? ❑ yes ❑ no

If yes, are they ❑ dependent or ❑ independent? If dependent, why? ____________________

Are there others with whom you relate closely and share personal experiences? ❑ no ❑ yes Who: ______________

If yes, are they ❑ dependent or ❑ independent? If dependent, why? ____________________

Secondary Caregivers for Children, Parents or Spouse:

Name	Location	Sex	Type*	For Whom?
1.				
2.				
3.				

Type of caregiver: Baby-sitter = B; Day Care = D; Home Health Aid = A; Nurse = N.

Have you made a living will? ❑ yes ❑ no **Have you assigned a Health Care Representative?** ❑ yes ❑ no

NAME:

INSTRUCTIONS: PUT ✓ IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

BIOLOGIC AND PSYCHOLOGIC FAMILY HISTORY

M - MATERNAL P - PATERNAL GM - GRANDMOTHER GF - GRANDFATHER	MOTH	FATH	M GM	M GF	P GM	P GF	BROTHER				SISTER				SPOUSE	CHILDREN			
							1	2	3	4	1	2	3	4		1	2	3	4
AGE (IF LIVING)																			
HEALTH (G) GOOD (B) BAD																			
CANCER																			
TUBERCULOSIS																			
DIABETES																			
HEART TROUBLE																			
HIGH BLOOD PRESSURE																			
STROKE																			
EPILEPSY																			
ALCOHOL DEPENDENCE																			
NERVOUS BREAKDOWN																			
ASTHMA, HIVES, HAYFEVER																			
BLOOD DISEASE																			
OTHER																			
AGE (AT DEATH)																			
CAUSE OF DEATH																			
DATE OF DEATH (MO/YR)																			

BIRTH HISTORY

WAS YOUR CHILD ...	MO/YR DATE	YES	NO	DID YOU OR THE CHILDS MOTHER ...
BORN VAGINALLY WITH FORCEPS ☐				HAVE ANY DELIVERY COMPLICATIONS ☐ YES ☐ NO
BORN BY CESAREAN SECTION				PLEASE EXPLAIN:
JAUNDICED AFTER BIRTH				
BORN WITH ANY SKIN MARKS, MOLES, OR ABNORMALITIES				HAVE ANY PRENATAL COMPLICATIONS OR EXPOSURES ☐ YES ☐ NO
BORN WITH ANY BIRTH DEFECTS				PLEASE EXPLAIN:
BORN WITH LOW APGARS				
IN NEED OF RESUSCITATION				IF A BOY, WAS YOUR CHILD CIRCUMCISED ☐ YES ☐ NO
PLEASE EXPLAIN:				HOSPITAL PEDIATRICIAN: MOTHER'S OBSTETRICIAN:

GROWTH & FEEDING BEHAVIOR

DID OR DOES YOUR CHILD ...	YES	NO	MO/YR START	MO/YR STOP	DID OR DOES YOUR CHILD ...	YES	NO	MO/YR START	MO/YR STOP
BREAST FEED					EAT SOLID FOOD				
BOTTLE FEED					HAVE FOUR TEETH				
USE A PACIFIER					DRINK FROM A CUP				
DRINK FORMULA WITH IRON					EAT TABLE FOOD				
DRINK FORMULA WITH LOW IRON					HAVE EIGHT TEETH				
DRINK SOY FORMULA					ASSIST WITH SILVERWARE FEEDING				
DRINK ELEMENTAL FORMULA (NUTRAMIGEN)					FEED INDEPENDENTLY				
DRINK FLOURINATED WATER					DEMONSTRATE ADEQUATE GROWTH				
DRINK 2% MILK					TAKE VITAMINS				
DRINK WHOLE MILK					LIST VITAMIN:				

ACTIVITY AND SOCIAL BEHAVIOR

DID OR DOES YOUR CHILD ...	YES	NO	MO/YR START	MO/YR STOP	DID OR DOES YOUR CHILD ...	YES	NO	MO/YR START	MO/YR STOP
HAVE GOOD HEAD CONTROL					STARTLE WITH LOUD NOISES				
ROLL OVER BACK TO FRONT					FOLLOW YOU WITH THEIR EYES				
SIT WITHOUT SUPPORT					LAUGH AND BABBLE				
CRAWL					EXPLORE THEIR SURROUNDINGS				
PULL UP					FORM WORDS				
WALK					MAKE TWO WORD SENTENCES				
RUN					FEAR STRANGERS				
UNDERSTAND DIRECTIONS					DISCIPLINE EASILY				

INFECTIONS, IMMUNIZATIONS AND HOSPITALIZATIONS

HAS YOUR CHILD EVER ...	MO/YR DATE	YES	NO	HAS YOUR CHILD EVER ...	MO/YR DATE	YES	NO
HAD CHICKEN POX				RECEIVED MMR IMMUNIZATIONS			
RECEIVED POLIO IMMUNIZATIONS HOW MANY ________	START			HAD RECURRENT INFECTIONS			
RECEIVED DPT IMMUNIZATIONS HOW MANY ________	START			HAD RECURRENT RASHES			
RECEIVED HIB IMMUNIZATIONS HOW MANY ________	START			HAD MEDICINE ALLERGIES			
BEEN HOSPITALIZED				PLEASE LIST:			

PLEASE EXPLAIN, NOTING DATES, DIAGNOSIS, PHYSICIANS, SURGEONS, AND HOSPITALS