

Chapel Hill Children & Adolescents' Clinic
301 Kildaire Rd, Suite 200
Chapel Hill, NC 27516
(919) 967-0771 Fax (919) 967-9207

FAMILY HISTORY
1 FORM PER BIOLOGICAL FAMILY

This form only needs to be filled out once for children who are related by both mother and father. If this is not the case, we need one filled out for each child.

DATE: _____

FOR OFFICE USE:

PATIENT NAME: _____

PATIENT NUMBER

DATE OF BIRTH: _____

SIBLING(S) AND DATES OF BIRTH: _____

Is patient adopted? Yes No

Is patient placed in foster home? Yes No

If yes, please give name and contact information for DSS case worker: _____

Do any family members (blood relatives) have: (list relative and medical problem)

Asthma? Yes No _____

Tuberculosis? Yes No _____

Sickle cell? Yes No _____

Cystic fibrosis? Yes No _____

Seasonal allergies? Yes No _____

Cancer? Yes No _____

Heart disease (<50 yo)? Yes No _____

Heart arrhythmia? Yes No _____

High blood pressure? Yes No _____

High cholesterol? Yes No _____

Diabetes (<50 yo)? Yes No _____

Seizures or epilepsy? Yes No _____

Kidney disease? Yes No _____

Liver disease? Yes No _____

Gastrointestinal disease? Yes No _____

Depression? Yes No _____

Anxiety? Yes No _____

Bipolar? Yes No _____

ADHD? Yes No _____

Intellectual Disabilities? Yes No _____

Thyroid problems? Yes No _____

Deafness? Yes No _____

Anemia? Yes No _____

Bleeding problems? Yes No _____

Alcohol abuse? Yes No _____

Drug abuse? Yes No _____

Immune probs/HIV/AIDS? Yes No _____

Unexplained death? Yes No _____

Any other family history you would like us to know? _____

How often in the last week have you felt depressed? (circle one)

0 1-2 3-4 5-7 days

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to kill you? Yes No

Do you feel safe in your home? Yes No