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

MEDICAL HISTORY
1 FORM PER CHILD

DATE: ____________________ FOR OFFICE USE:

PATIENT FULL NAME: ____________________ PATIENT NUMBER

FIRST MIDDLE LAST

DATE OF BIRTH: ______________ SEX __________

SIBLING(S): ____________________

____

HOME PHONE: (_______)____________________EMAIL ADDRESS: ____________________

PATIENT PHONE (if applicable): (______)____________________

STREET ADDRESS: ____________________ APT NO. ____________

CITY: ____________________ STATE: ____________________ ZIP: ________________

RACE: ____________________ □ Decline PREFERRED LANGUAGE: ____________________

ETHNICITY: □ Hispanic/Latino □ Filipino □ Not Hispanic/Latino □ Decline

HOW DID YOU HEAR ABOUT US?____________________

WOULD YOU LIKE TO CHOOSE A PRIMARY DOCTOR AT OUR OFFICE? IF YES, PLEASE WRITE WHICH PROVIDER YOU WISH TO CHOOSE: ____________________

* CHOOSING A PRIMARY CARE PHYSICIAN DOES NOT LIMIT YOUR OPTIONS TO CHOOSE TO SEE ANY PROVIDERS AT ANY TIME, AND ALSO DOES NOT GUARANTEE YOU WILL BE ABLE TO SEE YOUR PCP FOR ALL APPOINTMENTS. SICK VISITS AND WALK-IN WILL BE WITH THE PROVIDER AVAILABLE. EVERY ATTEMPT WILL BE MADE TO SCHEDULE YOU WITH YOUR CHOSEN PROVIDER WHENEVER POSSIBLE.

PREVIOUS PEDIATRICIAN:____________________CITY:_______________STATE:_______

ARE THERE OTHER DOCTORS INVOLVED IN YOUR CHILD'S CARE? IF YES, LIST: ____________________

____

PARENTS/GUARDIANS:

NAME:	HOME PHONE:	CELL PHONE:	WORK PHONE:	SSN:
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	

INSURANCE COMPANY NAME: ____________________

POLICYHOLDERS NAME: ____________________ SSN: ____________________

POLICY NUMBER: ____________________ GROUP NUMBER: ____________________

CLAIMS FILING ADDRESS: ____________________

EMERGENCY CONTACT INFORMATION: (NAME AND PHONE NUMBER OF NEAREST RELATIVE OR FRIEND OTHER THAN PARENT)

NAME: ____________________

PHONE: (____________)____________________ RELATIONSHIP: ____________________

PLEASE COMPLETE OTHER SIDE

Name of adult completing form: ____________________________ Relationship to patient: ___________

Birth weight: _____________ Was the baby full term? Yes No How many weeks early/late? ______

Vaginal □ C-section □ Did the baby stay in the NICU? Yes No If yes, for how long? __________

Did the baby go home with mom? Yes No

Did mom have any problems during pregnancy? Yes No
If yes, please list: ____

Did mom use any medications during pregnancy? Yes No
If yes, please list: ____

Did mom use alcohol/drugs during pregnancy? Yes No
If yes, please list: ____

Is your child up to date on their vaccines? Yes No Not Sure
Where has your child gotten vaccines? ____

Has your child been diagnosed with any medical problems? Yes No
If yes, please list: ____

Has your child been hospitalized since birth? Yes No If yes, please list: _________________________

Has your child had surgery? Yes No If yes, please list: _________________________

Has your child had any serious accidents? Yes No If yes, please list: _________________________

Is your child **allergic** to medicines? Yes No If yes, please list: _________________________

Is your child **allergic** to bee stings or foods? Yes No If yes, please list: _________________________

Does your child take any prescription medicines regularly? Yes No If yes, please list: _____________
____

Does your child see any special doctors (UNC/Duke/etc.)? Yes No If yes, please list: _____________
____

Does your child have:

Developmental problems?	Yes	No	If yes, please list: ____________________________________
Asthma?	Yes	No	If yes, please list: ____________________________________
Seasonal Allergies?	Yes	No	If yes, please list: ____________________________________
Diabetes?	Yes	No	If yes, please list: ____________________________________
Problems Seeing?	Yes	No	If yes, please list: ____________________________________
Problems Hearing?	Yes	No	If yes, please list: ____________________________________
Heart murmur/problem?	Yes	No	If yes, please list: ____________________________________
Bladder/kidney infections?	Yes	No	If yes, please list: ____________________________________
Epilepsy/Seizures?	Yes	No	If yes, please list: ____________________________________
Substance Abuse?	Yes	No	If yes, please list: ____________________________________
(Girls) Started periods?	Yes	No	If yes, please list: ____________________________________
(Girls) Period problems?	Yes	No	If yes, please list: ____________________________________
Gastrointestinal problems?	Yes	No	If yes, please list: ____________________________________

Do you have any concerns about how your child is doing in school? Yes No Describe: ___________
____