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

FAMILY HISTORY

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 ○