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

MEDICAL HISTORY

DATE: _____ FOR OFFICE USE:

PATIENT NAME (first, middle, last): _____ PATIENT NUMBER

PREFERRED NAME: _____

GENDER: _____

DATE OF BIRTH: _____

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 AVAIALBLE. 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:	DOB:	SSN:
	( )	( )		
	( )	( )		
	( )	( )		
	( )	( )		

INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICYHOLDERS NAME: _____ SSN: _____

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: _____

Has your child been hospitalized since birth 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: _____

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