

THE FAMILY DOCTOR

1728 Fordham Blvd, 151 Rams Plaza Chapel Hill, NC 27514

Today's Date: _____ **PEDIATRIC HEALTH HISTORY** Chart No: _____

Last Name: _____ First Name: _____ MI: _____ Birth Date: _____

Current Age: _____ Male Female

FAMILY INFORMATION:

Parent(s) or Guardian: _____

Home Address: _____

Home Phone Number: _____

Mother's Occupation: _____

Father's Occupation: _____

Please list the people your child lives with:

Name: _____ Age _____ Relationship to child _____

FAMILY MEDICAL HISTORY:

Has anyone in your child's family had:

Alcoholism, who: _____

Arthritis, who: _____

Asthma, who: _____

High Blood Pressure, who: _____

Cancer, who: _____

Depression, who: _____

Diabetes, who: _____

Glaucoma, who: _____

Heart Attack, who: _____

Migraine Headaches, who: _____

Obesity, who: _____

Seizures, who: _____

Stroke, who: _____

Thyroid Problems, who: _____

Tuberculosis, who: _____

CHILD'S MEDICAL HISTORY:

Child's regular health care provider: _____

Are your child's immunizations up to date? Yes No

Does your child have any chronic, on-going medical problems?

Does your child take any medicines on a regular basis?

Is your child allergic to any medicines?

Are there any smokers in your child's home? Yes No

Are there any guns in your child's home? Yes No

Is your child on a special diet? Yes No

Type: _____

Does your child use alcohol, tobacco or drugs? Yes No

Type: _____

Does your child visit the dentist regularly? Yes No

Does your child get regular checkups at the eye doctor? Yes No

Does your child wear a bicycle helmet when riding a bicycle or tricycle? Yes No

Does your child use a seatbelt or child safety seat when riding in the car? Yes No

Does your child know how to swim? Yes No

Does your child exercise regularly? Yes No

How many hours a day does your child watch television, play video games and use the computer? _____ Hours

Please list any concerns about your child that you would like to discuss with the health care provider:

DO NOT WRITE BELOW THIS LINE

Chronic Problem List:

Dx Date:

Medications:
