



John Carpenter, M.D. and Ernest Pugh, M.D.  
 889B Rio East Court, Charlottesville, VA 22901  
 Telephone (434) 978-7100 Fax (434) 978-4100

**HEALTH HISTORY--CHILD**

Chart No: \_\_\_\_\_

|                               |  |                   |  |             |  |
|-------------------------------|--|-------------------|--|-------------|--|
| Name: _____                   |  | Birth Date: _____ |  | Age: _____  |  |
| Social Security Number: _____ |  | Phone Day: _____  |  | Cell: _____ |  |
|                               |  |                   |  | Date: _____ |  |

**PAST MEDICAL HISTORY:** Has your child ever had any of the following illnesses?  
 Please circle and state **year of onset**

|                       |                     |                    |  |
|-----------------------|---------------------|--------------------|--|
| ADD or ADHD           | Diabetes            | Seizures           |  |
| Allergy/hayfever      | Heart problems      | Urinary infections |  |
| Anemia                | High cholesterol    | Venereal Disease   |  |
| Asthma                | High blood pressure | Other:             |  |
| Birth Defects         | Hives/eczema        |                    |  |
| Birth Complications   | Kidney disease      |                    |  |
| Colitis               | Migraines           | Other:             |  |
| Depression            | Pneumonia           |                    |  |
| Delays in Development | Premature Birth     |                    |  |

**HOSPITALIZATIONS:** Has your child ever been hospitalized for operations, illness, or injury?  
 Reason/Year \_\_\_\_\_ Reason/Year \_\_\_\_\_

|  |  |
|--|--|
|  |  |
|  |  |

**MEDICATIONS:** List current medications and dosage, including over the counter medications and supplements:

| Medication | Dose | Frequency | Medication | Dose | Frequency |
|------------|------|-----------|------------|------|-----------|
|            |      |           |            |      |           |
|            |      |           |            |      |           |

**ALLERGIES:** Allergy to any drug \_\_\_\_\_

X-Ray Dye \_\_\_\_\_ Food \_\_\_\_\_

**IMMUNIZATIONS :**

|   |     |    |
|---|-----|----|
| Is your child up to date?                   | Yes | No |
| Do you have the shot record?                | Yes | No |
| Any severe reactions to shots?              | Yes | No |
| Where were most recent immunizations given? |     |    |

**SCREENING EXAMS:** Has your child had screening exams?

|             |             |      |
|-------------|-------------|------|
| Anemia/iron | Cholesterol | Lead |
|             |             |      |

**SOCIAL HISTORY:**

Does anyone in the house smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

Was your house built before 1950? Yes \_\_\_\_\_ No \_\_\_\_\_

If your house was built before 1978, do you have chipped or peeling paint? Yes \_\_\_\_\_ No \_\_\_\_\_

Patient Name: \_\_\_\_\_ Chart No: \_\_\_\_\_

Does your child live with you all the time? \_\_\_\_\_ Who else lives with you? \_\_\_\_\_

Does your child have problems in school? \_\_\_\_\_

Does your child have trouble making and keeping friends? \_\_\_\_\_

Are the child's parents married? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY HISTORY:** Has any member of your child's family (parents, brothers, sisters,) had any of the following?

Please state who in the family. F=Father M=Mother S=Sibling

|                     |   |   |   |                  |   |   |   |
|---------------------|---|---|---|------------------|---|---|---|
| Alcoholism          | F | M | S | Cancer – Breast  |   | M | S |
| Asthma              | F | M | S | Cancer – Colon   |   | M | S |
| Depression          | F | M | S | Cancer – Ovarian | F | M | S |
| Diabetes            | F | M | S | Cancer – Other   | F | M | S |
| Heart disease       | F | M | S | Hives/Eczema     | F | M | S |
| High blood pressure | F | M | S | Epilepsy         | F | M | S |
| High cholesterol    | F | M | S | Other            | F | M | S |
| Osteoporosis        | F | M | S |                  | F | M | S |
| Stroke              | F | M | S |                  | F | M | S |

| Please mark below: | IF LIVING |                 | IF DECEASED  |                |
|--------------------|-----------|-----------------|--------------|----------------|
|                    | AGE       | STATE OF HEALTH | AGE AT DEATH | CAUSE OF DEATH |
| FATHER             |           |                 |              |                |
| MOTHER             |           |                 |              |                |
| BROTHER 1          |           |                 |              |                |
| BROTHER 2          |           |                 |              |                |
| SISTER 1           |           |                 |              |                |
| SISTER 2           |           |                 |              |                |

**TEENS COMPLETE THE FOLLOWING:**

Do you smoke? Yes No Number per day? \_\_\_\_\_

Do you drink alcoholic beverages? Yes No How much? \_\_\_\_\_

(If you use illicit drugs, please speak to us in confidence.)

Do you exercise? Yes No How often? \_\_\_\_\_

How would you describe your weight? Underweight \_\_\_\_\_ About Right \_\_\_\_\_ Overweight \_\_\_\_\_

Do you have a friend you can talk to about almost everything? \_\_\_\_\_

What school do you attend? \_\_\_\_\_

What is your grade average, most recently? \_\_\_\_\_

Do you do any organized activities outside the classroom? \_\_\_\_\_

Hobbies/Social activities: \_\_\_\_\_

What percentage of the time do you wear a seatbelt? \_\_\_\_\_

Do you use a cell phone while driving? \_\_\_\_\_

Is there anything you would like to talk to the doctor about? \_\_\_\_\_

**For Girls Only:** Do you have periods? \_\_\_\_\_ Are they regular? \_\_\_\_\_

Do you have bad PMS? \_\_\_\_\_