

THANK YOU FOR CHOOSING THE PHYSICIANS AT **RALEIGH CHILDREN & ADOLESCENTS MEDICINE**
TO BE YOUR CHILD'S DOCTOR. HERE ARE A FEW QUESTIONS TO GET YOUR WELL VISIT STARTED:

YOUR CHILD'S PREFERRED NAME: _____

TUBERCULOSIS (TB) SCREENING QUESTIONS –	YES	NO
1. Has any household member ever had a positive TB skin test or TB disease (This includes your child, extended family, frequent visitors, overnight guests, babysitters or daycare providers)?		
2. Does your child spend time with anyone who has recently been in jail, in a homeless shelter, in another residential institution, or who has HIV?		
3. Were you or your child born outside of the United States?		
4. Has your child or any household member lived outside of the United States for more than 1 month or recently traveled outside of the US?		

WHAT CAN YOU TELL US ABOUT YOUR CHILD'S PAST MEDICAL HISTORY?	WHAT CAN YOU TELL US ABOUT YOUR CHILD'S FAMILY SOCIAL HISTORY?																												
<p><i>Past Hospitalizations –</i></p> <p><i>Past Surgeries –</i></p> <p><i>Current Medications –</i></p> <p><i>Allergies –</i></p> <p><i>Other Medical Issues –</i></p>	<p><i>Father's preferred name –</i></p> <ul style="list-style-type: none"> <i>Father's occupation –</i> <p><i>Mother's preferred name –</i></p> <ul style="list-style-type: none"> <i>Mother's occupation –</i> <table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td><i>Parents married?</i></td> <td></td> <td></td> </tr> <tr> <td><i>Parents living together?</i></td> <td></td> <td></td> </tr> <tr> <td><i>Pets in the home?</i></td> <td></td> <td></td> </tr> <tr> <td><i>Anyone smoke at home?</i></td> <td></td> <td></td> </tr> <tr> <td><i>Guns in the home?</i></td> <td></td> <td></td> </tr> <tr> <td><i>Water source – city water?</i></td> <td></td> <td></td> </tr> <tr> <td><i>Water source – well water?</i></td> <td></td> <td></td> </tr> <tr> <td><i>Water source – bottled water?</i></td> <td></td> <td></td> </tr> </tbody> </table>			YES	NO	<i>Parents married?</i>			<i>Parents living together?</i>			<i>Pets in the home?</i>			<i>Anyone smoke at home?</i>			<i>Guns in the home?</i>			<i>Water source – city water?</i>			<i>Water source – well water?</i>			<i>Water source – bottled water?</i>		
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WHAT CAN YOU TELL US ABOUT YOUR CHILD'S FAMILY MEDICAL HISTORY? PLACE A CHECK IN EACH BOX THAT APPLIES.	Diabetes	Asthma/Allergies	Seizures/Neurologic disease	Birth/Genetic defect	Psychiatric (depression, bipolar, OCD, etc.) disorder	Autism/Develop. delay	Blood disorder	Cancer	Thyroid disease	Heart disease/Stroke	High cholesterol	Kidney disease	Stomach/Intestinal prob.	Scoliosis	Other Family Medical History
<i>Father</i>															
<i>Mother</i>															
<i>Siblings</i>															
<i>Paternal Grandfather</i>															
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LIST **ANY CONCERNS** YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR ON THE BACK OF THIS SHEET