**Pediatric Health History Form**
Tina Joyce D.O., LLC

Child's Name: ___________________________________________ D.O.B. ____/____/____ AGE: ________

Child's primary caregiver: __________________________________________________________________

Is this child yours by (please circle one): Birth / Adoption /Stepchild / Other ________________________

Present health concerns: ___________________________________________________________________

Please list all medication(s)/Vitamin(s): ______________________________________________________

__________________________________________________________________________________________

Please list all allergies and the corresponding reactions to the following:

Medications: ______________________________________________________________________________

Vaccinations: _____________________________________________________________________________

Food: ____________________________________________________________________________________

Environmental/Chemical: ___________________________________________________________________

**PAST MEDICAL HISTORY:**

Has your child had (please circle all that apply):

Chicken Pox / Measles / Mumps / Rubella / Meningitis / Tuberculosis (TB)

Please describe any major medical problems and their dates: _____________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Hospitalizations (with dates):_______________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Broken Bones or severe strains/sprains (with dates): ____________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Major falls, traumas or other injuries (with dates): _____________________________________________

__________________________________________________________________________________________

**FAMILY HISTORY:**

Please circle any family history (please state who had it):

Alcohol/Drug abuse ________ Heart disease or stroke before 60__________ Seizures _____________

Asthma/Eczema ___________ High blood pressure ____________________ Thyroid disease ______

Birth defect _______________ Kidney disease _________________________

Bleeding/clotting problem _______________ Depression/Anxiety _______________

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**SOCIAL HISTORY:**

Birthplace: _______________________________________________________

Please list who lives at home:

| Name | Age | Relationship | Education | Do they smoke? |
|---|---|---|---|---|
| ________________________ | ______ | ___________ | ____________ | Y N |
| ________________________ | ______ | ___________ | ____________ | Y N |
| ________________________ | ______ | ___________ | ____________ | Y N |
| ________________________ | ______ | ___________ | ____________ | Y N |
| ________________________ | ______ | ___________ | ____________ | Y N |

Are the child's parents (Please circle): Married / Unmarried /Separated /Divorced

Mother's occupation: _____________ _____________ Father's occupation: ____ _________________

Do you have pets at home? Yes / No

If Yes what type?_______________________________________________________________________

Concerns about your child (Please circle):

None / Alcohol / Tobacco / Drug use / Sexual activity / Aggressive behavior / Other _________________

Is violence at home a concern? Yes / No

Are there guns at home? Yes / No

If yes, what type of gun? Handgun / Shotgun / Rifle / Other _____________

Is the gun locked up? Yes / No

Any concerns about lead exposure? (old home/plumbing/peeling paint/toys) Yes / No

Average time spent during the school year on: TV ______ Computer ______ Video games _______

Average time spent during the summer on: TV ______ Computer ______ Video games _______

**FAMILY HEALTH HABITS:**

Does your home have a smoke detector? Yes / No

How often does your child use a seatbelt or if applicable a car seat (Please circle)?

Never / Rarely / Sometimes / Often / Every time

Does your child ride a bicycle? Yes / No

If yes, how often does he/she use a helmet (Please circle)?

Never / Rarely / Sometimes / Often / Every time

Do you feel that you live in a safe place? Yes /No

Is there risk of abuse or neglect of your child? Yes / No

Have you had a child taken away from you? Yes / No

If Yes, why? __________________________________________________________________________

Did you get him/her back? Yes / No

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## Please fill this page out if your child is younger than 4 years of age:

**PREGNANCY & BIRTH:**

Where there any medical problems during pregnancy (Please circle)? Yes / No

If yes, what were the issues? ______________________________________________________________

______________________________________________________________________________

Was the delivery (Please circle) a vaginal birth or a Caesarian section (C-section)?

If applicable, why was it a C-section? ________________________________________________________

Was the delivery premature (less than 36 weeks at birth)? Yes / No

If yes, why?________________________________________________________________________

Were there any medical problems that arose during delivery? Yes/ No

If yes, please explain :_____________________________________________________________

Birth weight: ________________ Birth length: _______________

APGAR score after 1 minute ____ after 5 minutes _____

**NUTRITION AND FEEDING:**

Was your child breast fed? Yes / No Are you still breast feeding? Yes / No

If not, for how long was your child breast fed? _______________

Does your child have any dietary problems? Yes / No

If yes, please specify: ____________________________________________________________

What type of milk is you child drinking now (please circle all that apply)?

Cow (including non-fat, 1% fat, 2% fat, and whole milk) / Soy / Rice / Almond

How many cups of milk does your child drink (1 cup equals 8 ounces)? ___________________________

How many cups of juice does your child drink (1 cup equals 8 ounces)? ___________________________

**DEVELOPMENT:**

At what age did you child:

Sit alone: __________________ Walk alone: __________________ Say words: ___________________

Daytime toilet train: ________________

How many hours per night does your child sleep? _______ Naps (number and length)_______________

Are there any sleeping problems? ________________________________________________________

**DENTAL HISTORY:**

Has your child seen a dentist? Yes / No

If yes, when was your last dental visit? _________ What is the dentist's name? _____________________

**SOCIAL:**

Does our child have a best friend? Yes / No

What is the current child care situation (Please circle)?

At home parent / Grandparent / Daycare _______hours per week / School / Other__________________