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

NAME: _____

DATE OF BIRTH: _____

AGE: _____

Your relationship to child: _____

Child's previous doctor/primary care provider: _____

Present health concerns:

Medicines/Vitamins:

Herbs/Home Remedies:

Allergies/Reactions to medicines or vaccinations:

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: Birth Adoption Stepchild Other:

Please indicate any medical problems during pregnancy

None Specify: _____

Delivery by Vaginal birth Caesarean

If Caesarean, why? _____

Birth weight: _____ Birth length: _____

APGAR score 1 min. _____ 5 min. _____

Please indicate any medical problems during the baby's newborn period None (If premature, how early?)

_____

Other problems: _____

NUTRITION & FEEDING

Was your child breastfed? No Yes

If so, how long?

Has your child had any unusual feeding/dietary problems? No Yes If yes, specify:

_____

Milk intake now: Type Cow's milk (Nonfat 1% fat 2% fat Whole)

Soy milk Rice milk

Average ounces per day (Note: 8 ounces = 1 cup)

_____

SLEEP

Hours per night _____

Naps (number & length) _____

Any sleep problems? _____

DEVELOPMENT

At what age did your child: Sit alone _____

Walk alone _____ Say words _____

Toilet train (daytime) _____

Girls only: Age at first menstrual period _____

DENTAL HISTORY

Has child been seen by a dentist? No Yes

If so, how often? _____

Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:

Chickenpox Measles Mumps

Rubella Meningitis Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint) No Yes

Do any household members smoke? No Yes

TV – hours per day _____

Computers – hours per day _____

Video games – hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

_____

_____

_____

Hospitalization/operations (with dates):

Broken bones or severe sprains:

FAMILY HISTORY

Please indicate any deaths of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism

High cholesterol

Cancer, specify type

High blood pressure

Heart disease

Stroke

Depression/suicide

Bleeding or clotting disorder

Genetic disorders

Asthma/COPD

Diabetes

Other:

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents Married Unmarried Separated Divorced

If divorced or separated, when?

Mother's Occupation

Mother's Employer

Father's Occupation

Father's Employer

Child care situation Parents Others (specify who and how often)

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern? No Yes

Are there guns in the home? No Yes

SCHOOL HISTORY

Did/does your child attend school or preschool?

No Yes

Current grade

Name of school

Any concerns about school performance?

Any concerns about relationship with:

Teachers No Yes

Peers No Yes

If more than 4 years old: does your child have a best friend? No Yes

Sports/exercise: Type

How often?

How long (minutes)?

REVIEW OF SYMPTOMS: Please check any current problems your child has on the list below:

General

____ Fevers/chills/excessive sweating
____ Unexplained weight loss/gain

Eyes

____ Squinting/"crossed" eyes/ asymmetric gaze

Ears/Nose/Throat

____ Unusually loud voice/hard of hearing
____ Mouth breathing/snoring
____ Bad breath
____ Frequent runny nose
____ Problems with teeth/gums

Cardiovascular

____ Tires easily with exertion
____ Shortness of breath
____ Fainting

Respiratory

____ Cough/wheeze
____ Chest pain

Gastrointestinal

____ Nausea/vomiting/diarrhea
____ Constipation
____ Blood in bowel movement

Genitourinary

____ Bedwetting
____ Pain with urination
____ Discharge: penis or vagina

Musculoskeletal

____ Muscle/joint pain

Skin

____ Rashes
____ Unusual moles

Allergy

____ Hay fever/itchy eyes

Neurological

____ Headaches
____ Weakness
____ Clumsiness

Psychiatric/Emotional

____ Speech problems
____ Anxiety/stress
____ Sleep issues
____ Depression
____ Nail biting/thumb sucking
____ Bad temper/breath holding/ jealousy

Blood/Lymph

____ Unexplained lumps
____ Easy bruising/bleeding