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 12 -17 years old:

SOCIAL:

Do you drink alcohol? Yes / No

If yes, how many drinks a day? 1 / 2 / 3 / 4+ How many times a week? 1 / 2 / 3 / 4 / 5 / 6 / 7

Have you ever used a street drug? Yes / No

If yes, which one(s) (Please circle all that apply):

Marijuana / Cocaine / Heroin / Methadone / Speed / Prescription pain pills / Other _____

Have you been sexually active? Yes / No If yes, how many partners _____

Do you feel anxious? Yes / No

If yes, when? _____ How often? _____

Do you feel depressed? Yes / No

If yes, when? _____ How often? _____

DEVELOPMENT:

How many hours per night does your child sleep? _____

Are there any sleeping problems? _____

Sleep aids used? Yes / No

If yes, what type? _____

DENTAL HISTORY:

Has your child seen a dentist? Yes / No

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

SCHOOL HISTORY:

Current grade in school: _____

Any concerns about school performance? Yes / No

If yes, what are those concerns? _____

Any concerns about relationships with:

Teachers: Yes / No

If yes, please explain? _____

Students: Yes / No

If yes, please explain? _____

What type of sports does your child participate in? _____

How long are the practices? _____

What other exercise does your child do? _____

How often does your do this exercise? _____

GIRLS ONLY:

Age of first period _____