HealthPoint Family Care Patient Name:_____ Date of Birth:_____

Name of person completing this form:_____Signature:_____

Relationship to student: [ ] Mother [ ] Father [ ] Grandmother [ ] Grandfather [ ] Guardian [ ] Foster

I understand that it is my responsibility to notify the office about changes in health history.

History	Child	Mother	Father	brother/sister	Grandfather	Grandmother	History	Child	Mother	Father	brother/sister	Grandfather	Grandmother
Abnormal bleeding							Heart murmur						
Aids/HIV infection							Hepatitis						
Alcohol/drug abuse							High blood pressure						
Allergies							High cholesterol						
Anemia							Acid Reflux / Heartburn						
Anxiety							Immune System Problems						
Arteriosclerosis							Implant, prostheses, artificial joints						
Arthritis							Kidney trouble						
Artificial heart valves							Lead poisoning or exposure						
Asthma							Liver disease or Jaundice						
Back injury							Low blood pressure						
Blood or Bleeding disorder							Mitral-valve prolapsed (MVP)						
Bowel problems							Muscle problems						
Breathing problems							Painful swollen joints						
Bronchitis							Persistent cough						
Cancer or tumor							Persistent diarrhea						
Cough that produces blood							Persistent swollen glands in neck						
Damaged heart valves							Problems with mental health						
Depression							Recent weight loss						
Diabetes							Respiratory Problems						
Emotional problems							Rheumatic heart disease						
Emphysema							Sexually transmitted disease						
Epilepsy or Seizures							Sinus trouble						
Fainting Spells							Skin problems						
Gallbaldder or stones							Stomach problems						
Hay fever							Stomach ulcer						
Hearing or speech problem							Stroke						
Heart attack							Thyroid problems						
Heart disease or problems							Tuberculosis						
Other:							Vision problems						
Other:							Other:						

Is your child pregnant or nursing? [ ] Yes [ ] No	Does your child wear contact lenses? [ ] Yes [ ] No
Is your child allergic to any medications? Yes No	**Does your child have environmental or food allergies? Yes No**
Allergy:	**Reaction:**

What are your child's main health concerns:_____

What are your child's main dental concerns:_____

HealthPoint's risk assessment is a tool for our providers to partner with you to promote a healthy lifestyle for your child!

HealthPoint

Surgeries and Hospitalizations in last 5 years:

Check if None ☐

[ ] PE tubes [ ]Radiation Treatment

[ ] Tonsillectomy [ ]oral/IV bisphosphonates

[ ] Valve Replacement

Other:

Child's Grade in School?____ # days absent this year? ___

How are they doing in school? [ ] doing well or [ ] poor

Does the child live in a home built before 1970? Yes No

Does anyone in the home smoke? [ ] Yes [ ] No

Who smokes in home? Mother Father Sibling Other

Is there a gun in the home? [ ] Yes [ ] No

Any concerns about alcohol or drugs? [ ] Yes [ ] No

Does your child use tobacco: Yes No

if "yes" [ ] Cigerette [ ]Smokeless

Amount: ___pack(s)/can(s) per [ ] day or [ ] week

How many years?

Has the child been physically abused? Yes No

Has the child been sexually abused? Yes No

Other concerns:

Preferred Pharmacy: _____

Pharmacy phone number: _____

Pharmacy city:

Prescriptions are sent electronically to the pharmacy

Specialists Caring for Your Child:

Check if None ☐

Primary Care Physician: HealthPoint ☐ or list below

Name of physician or group: _____

Phone number: _____

Date of last physical: _____

Name of Dentist: _____

Dentist phone number: _____

Date of last dental exam:

Current Medications prescription, over the counter, or herbal — Check if no medications ☐	**Instructions** (1 time a day, 2 times a day)	**Dose** (# mg, mg/mm or unit)

Child's parents are: [ ] Married [ ] Separated [ ] Divorced [ ] Other

Who's the primary Caregiver for this child: [ ] Mother [ ] Father [ ] Grandmother [ ] Grandfather [ ] Other

What are custody arrangements?

Immediate Family Name:	**Age**	**Current Health?**	**Lives With Child?**
Mother		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Father		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Guardian		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no
Sibling		[ ] living [ ] sick [ ] deceased	[ ] yes [ ] no