![C:\Users\6\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\clip_art_for_website[1].jpg]()PUTNAM PEDIATRIC MEDICINE PLLC

*667 Stoneleigh Avenue Suite 116*

*Carmel, New York 10512*

*Phone: 845-279-9652 or 845-279-5131 Fax: 845-279-3606*

Patient History Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Members

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family member | NAME | D.O.B | Do they live with Pt. | Healthy? |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Siblings: |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Pregnancy and Delivery

|  |  |  |
| --- | --- | --- |
| Birth Weight: lb oz | Birth Height: in |  Details |
| Illnesses during pregnancy? |  Yes No  |  |
| Premature or late delivery? |  Yes No  |  |
| Problem with delivery? |  Yes No  |  |
| Any problems in the nursery? |  Yes No |  |
| Did the baby go home with mom? |  Yes No |  |
| Was the baby jaundice? |  Yes No |  |
| Was the baby cyanotic (blue)? |  Yes No |  |
| Did you have a cesarean? |  Yes No |  |

Family History

Does any family relative have any of the following conditions?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Condition | Yes | No | Relation to Patient | Condition | Yes | NO | Relation to Patient |
| Allergy |  |  |  | Anemia |  |  |  |
| Diabetes |  |  |  | Epilepsy |  |  |  |
| High B/P |  |  |  | Mentally challenged |  |  |  |
| Heart disease |  |  |  | Thyroid problems |  |  |  |
| High cholesterol |  |  |  | Arthritis  |  |  |  |
| Stroke |  |  |  | Infant deaths |  |  |  |

Family History Continued

Does any family relative have the following conditions?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Condition | Yes | No | Relation to Patient | Condition | Yes | No | Relation to Patient |
| Miscarriages |  |  |  | Liver Disease |  |  |  |
| Tuberculosis |  |  |  | Kidney Disease |  |  |  |
| Cancer |  |  |  | Asthma |  |  |  |

Patient’s Past Medical History

Has your child had a history of any of the following?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Details |  | Yes | No | Details |
| Hospitalization |  |  |  | Heart problems |  |  |  |
| Surgery |  |  |  | Skin problems |  |  |  |
| Serious accidents |  |  |  | Convulsion/Seizure |  |  |  |
| Serious Illness |  |  |  | Bowel problems |  |  |  |
| Food allergy |  |  |  | Urinary problem |  |  |  |
| Bee sting allergy |  |  |  | Menstrual problems |  |  |  |
| Medication Allergy |  |  |  | Coordination problems |  |  |  |
| Eye/vision problems |  |  |  | Recurrent abdominal pain |  |  |  |
| Frequent ear infection |  |  |  | Behavior problems |  |  |  |
| Frequent tonsillitis |  |  |  | Emotional problems |  |  |  |
| Recurrent bronchitis |  |  |  | School problems |  |  |  |
| Asthma |  |  |  | Chickenpox |  |  |  |
| Pneumonia |  |  |  | Any problem we should be aware of |  |  |  |

Please provide past immunization records if applicable

Date completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_