PREFERRED PEDIATRICS OF ROCKLAND

100 Route 59 • Suffern, New York 10901 • Telephone: 845-357-5020

PATIENT MEDICAL HISTORY

Name:_____ □ **F** □ **M** **Date of Birth:** ___/___/____ **PRN:**_____

Date filled: ___/___/____ **History Given By:** _____ **Previous Pediatrician:**_____

Allergies:_____

BIRTH HISTORY:

PREGNANCY COMPLICATION	YES	NO	PREGNANCY COMPLICATION	YES	NO	PREGNANCY COMPLICATION	YES	NO
Smoking			Alcohol/Drug Use			Medication		
Infection			Bleeding			Hypertension		
Preclampsia/Toxemia			Premature Labor			Gestational Diabetes		

NEWBORN:

Gestational Age: **Full Term/ Preterm** ___Weeks Type of Delivery: **NSVD/C-section**, Secondary to:_____

Hospital: _____ Birth Weight: _____lb. Length: _____ in Head Circumference: _____in

Any Neonatal Problems? _____

NUTRITION HISTORY:

- ***Infancy***

  Breast: _____ Bottle: _____ Formula: _____ Reflux: □**Yes** □**No**

- ***Childhood/Adolescence***

  Any Special Dietary Requirements? □**Yes** □**No** If yes, explain: _____.

  Any History of Constipation? □**Yes** □**No** Primary Pharmacy: _____.

DEVELOPMENTAL HISTORY:

	YES	NO	IF YES, CIRCLE ALL THAT APPLY.			
Developmental Delay			Gross Motor	Fine Motor	Speech	Global
Early Intervention Services			PT	OT	Speech	
Does your child have and IEP or 504?			An IEP is an Individual Education Plan given at school.			

PATIENT'S PAST MEDICAL HISTORY: ****If additional space is needed, please see reverse****

Significant Illnesses: _____

Hospitalizations:_____

Menstrual History: Age of onset:____ years Last Menstrual Period: ___/___/____ Any problems? _____

FAMILY HISTORY:

	MATERNAL		PATERNAL			MATERNAL		PATERNAL	
	YES	NO	YES	NO		YES	NO	YES	NO
Heart Disease					Liver/ Kidney Disorder				
High Blood Pressure					Gastrointestinal Disorder				
Hypercholesterolemia					Learning Disabilities				
Bleeding Disorders					Seizures				
Rheumatologic Disorders					Migraines				
Psychiatric Disorders					Diabetes				
Asthma					Hyper/Hypo Thyroidism				
Tuberculosis					Seasonal Allergies				
Cancer					Alcohol/ Drug Abuse				

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SOCIAL HISTORY:

Do you live in a □ **House or** □ **Apartment** ? Age of home? _____ Years Number of household members _____People

Any smokers in household? □**Yes** □**No** Any pets at home? □**Yes** □**No** If yes, what kind of pets? _____

Are there any specialist involved in your child's care? □**Yes** □**No**

If YES, please complete the following

Name of Physician	Specialty	Reason

Is your child currently on any medication? □**Yes** □**No**

If YES, please complete the following

Name of Medication	Dosing	Reason For Taking

Is there any additional information you would like to share with our physician?

_____

_____

_____

_____

_____

Physician/Nursing Notes:

REVIEWED BY:_____ **DATE:** ___/___/_____