Monroe Pediatric Associates, P.C.

A Division of Allied Pediatrics of New York
70 Gilbert Street · Monroe, NY 10950
(845)782-8616

DATE: _____

PATIENT MEDICAL HISTORY

Patient's Name: _____ Sex:_____ DOB:_____ History given by: _____

ALLERGIES:_____ Previous Pediatrician: _____

BIRTH HISTORY: Maternal age at time of birth: _____

PREGNANCY COMPLICATIONS

	YES	NO		YES	NO		YES	NO
Smoking			Alcohol/Drug Use			Medications		
Infections			Bleeding			Hypertension		
Preclampsia/Toxemia			Premature Labor			Gestational Diabetes		

NEWBORN:
Gestational Age: _____ Type of Delivery: _____ Hospital: _____

Birth Weight: _____ Length: _____ Head Circumference: _____

Any Neonatal Problems? _____

NUTRITIONAL HISTORY:

Infancy

Breast: _____ Bottle: _____ Formula Name: _____ Reflux: Yes _____ No_____

Childhood/Adolescence

Any Special Dietary Requirements? Yes ____ No ____ If yes, explain _____
Any History of Constipation? Yes ____ No ____

Primary Pharmacy Name: _____

DEVELOPEMENTAL HISTORY:

IS THERE ANY HISTORY OF THE FOLLOWING?

	YES	NO	If yes, please circle all that apply…
Developmental Delay			Gross Motor Fine Motor Speech Global
Early Intervention Services			PT OT Speech
Does Your Child Have an IEP or 504?			An IEP is an "Individualized Education Plan" given at school

PAST MEDICAL HISTORY:

If additional space is needed, please see reverse side

Significant Illnesses: _____
Hospitalizations:_____ Surgeries:_____
Menstrual History: Age of Onset _____ Any Problems? _____

FAMILY HISTORY:

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

SOCIAL HISTORY:

Do you live in a House __ or Apartment __ Age of House/Apartment: _____ No. of Members in Household: ____
Smokers? Yes ___ No ___ Pets? Yes ___ No ___ If yes, what kind? _____

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PATIENT MEDICAL HISTORY

Are there any specialists 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 medications? Yes ____ No ____

If yes, please complete the following:

NAME OF MEDICATION	DOSING	REASON FOR TAKING IT

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

_____

_____

_____

_____

_____

Physician/Nursing Notes:

_____

_____

_____

_____

_____

_____