Stony Brook Children's

Todays' Date ___/____/____

Patient Medical History Form

Name: _____ DOB ____/____/____ Age_____ Sex ☐ M ☐ F

Reason for Visit: _____

Birth History

Patient's birth hospital:_____
(Name) (City) (State)

Vaginal Birth ☐ or Cesarean Delivery ☐
NICU ☐ or Well Nursery ☐
Birth Weight _____
Discharge Weight _____
Birth Length _____
Jaundice No ☐ Yes ☐
Breeched No ☐ Yes ☐
Congenital hip dislocation No ☐ Yes ☐
Passed hearing test No ☐ Yes ☐

Received first Hep B shot No ☐ Yes ☐, If yes date ____/ ____/ ____

Any medications/Illness/ Complications during pregnancy:_____

Past Medical/ Hospitalizations/Surgeries
Any Major Illness: No ☐ Yes ☐ List them: _____ _____ _____ Past hospitalizations No ☐ Yes ☐ When/Why:_____ _____ _____ Any past surgeries No ☐ Yes ☐ When/Where: _____ _____ _____

Current Medications (Including over the counter/vitamins)	
Medication Name	**Dosage**

Medication and Food Allergies			
Medication/ Food	**Reaction**	**Medication/Food**	**Reaction**

Family Medical History	
Condition/Disease (check all that apply)	**Family Member (list members below)**
☐ Asthma	
☐ Visual Problems	
☐ High Cholesterol	
☐ Heart Disease	
☐ Kidney Disease	
☐ Cancer. What Kind?	
☐ Alcohol Abuse	
☐ Epilepsy	
☐ Hearing Problems	
☐ High Blood Pressure	
☐ Diabetes	
☐ Thyroid Disease	
☐ Smoking	
☐ Drug Abuse	