|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STONY BROOK PEDIATRICS PC, FAAP****Dansville Office 22 Red Jacket St Dansville NY 14437 PH (585) 335 5200 Fax (585) 335 5037****Geneseo Office 50 E South St, Suite 400, Geneseo NY 14454 PH (585) 243 9340 Fax (585) 243 9344****PATIENT INFORMATION SHEET** **PATIENT INFORMATION** TODAY’S DATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LAST FIRST MI PREFER TO BE CALLED DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| RACE/ETHNICITY SELECT ALL THAT APPLY* American Indian/Alaskan Native
* Asian
* Black/African American
* White
 | * Native Hawaiian/Pacific Islander
* Decline
* Hispanic/Latin/Spanish Origin
 | PATIENT **PRIMARILY** LIVES WITH:* BOTH PARENTS
* MOTHER
* FATHER
* GUARDIAN
* GRANDPARENT
* FOSTER PARENT
 |
|  |
|  |  |
| PREFERRED LANGUAGE:IS A TRANSLATOR REQUIRED? YES / NO |
| PARENT/LEGAL GUARDIAN PREFERRED METHOD OF COMMUNICATION

|  |  |
| --- | --- |
| * Telephone
* Mail
 | * Web Enable
* Decline
 |

MAY WE LEAVE A VOICE MAIL MESSAGE REGARDING APPOINTMENTS? YES NOPREFERRED PHARMACY NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TOWN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PLEASE PROVIDE ANY CURRENT CUSTODY ORDERS (IF APPLICABLE)**  |

**MOTHER/LEGAL GUARDIAN’S INFORMATION** MOTHER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LAST FIRST MI PREFER TO BE CALLED DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL SEC.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SEX\_\_\_\_\_\_\_\_\_\_\_\_RACE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALTERNATE PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE ( \_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL (to be web enabled)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYMENT ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CITY STATE ZIP  **MARITAL STATUS: SINGLE MARRIED RE-MARRIED DIVORCED WIDOWED** **FATHER/LEGAL GUARDIAN’S INFORMATION** FATHER’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LAST FIRST MI PREFER TO BE CALLED DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL SEC.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SEX\_\_\_\_\_\_\_\_\_\_\_\_RACE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MAILING ADDRESS IF DIFFERENT THAN ABOVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALTERNATE PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE ( \_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYMENT ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CITY STATE ZIP  **MARITAL STATUS: SINGLE MARRIED**  **RE-MARRIED DIVORCED WIDOWED**  **INSURANCE INFORMATION** PRIMARY INSURANCE COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME OF POLICY HOLDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY HOLDER’S DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECONDARY INSURANCE COMPANY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME OF POLICY HOLDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY HOLDER’S DATE OF **BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\*\* PATIENT’S WITH PRIMARY INSURANCE WITH APPLICABLE COPAYS/DEDUCTIBLES ARE REQUIRED TO PAY THE CONTRACTUAL COPAYMENTS AT THE TIME OF SERVICE**\*\***EMERGENCY CONTACT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (NAME OF PERSON THAT DOES NOT RESIDE AT YOUR RESIDENCE )RELATIONSHIP TO PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*\*\*\*\*\* CONTINUED ON NEXT PAGE \*\*\*\*\*\* |
| **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN** PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE I, the undersigned, authorize payment of medical benefits directly to Stony Brook Pediatrics for any services rendered by Stony Brook Pediatrics. This irrevocable assignment and transfer will be for the recovery of insurance payments but shall not be an obligation of Stony Brook Pediatrics to pursue any such right of recovery. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE**. I also authorize you to release to the insurance company any information concerning healthcare, treatment, or supplies provided. I permit a copy of this authorization to be used in place of the original. **SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **PAYMENT AGREEMENT** It is the policy of Stony Brook Pediatrics and your insurance company that charges for services rendered by our physician(s) and staff including contractual co-pays and deductibles are paid **AT THE TIME OF SERVICE** unless other formal arrangements have been made in advance with our business office. For your convenience, Stony Brook Pediatrics will file electronic insurance claims; however, it will be your responsibility to provide our office with the necessary information and signed authorization for filing insurance. This information and authorization must be provided to our office at your first visit, accompanied with a copy of your health insurance card(s). I agree to the above financial agreement for any services provided to me by Stony Brook Pediatrics **SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PRIVACY POLICY**Copies of the Privacy Policy for Stony Brook Pediatrics are available on request. Please ask our staff for your copy at your initial visit.I acknowledge that I have access to a copy of the “Notice of Privacy Practices” from Stony Brook Pediatrics PC.**SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Initial History Questionnaire**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Name |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Form Completed by /Relationship to patient Date Completed |

Household

Please list all adults and children living in the child’s home.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | **Relationship to Child**  | **Birth Date**  | **Notes**  |
|   |   |   | Are there any adults or siblings not listed? If so, please list their names, date of birth, relationship to the child and where they live.   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

Birth History

|  |  |
| --- | --- |
| Birth weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was the baby born at term? \_\_\_\_\_\_ Early? \_\_\_\_\_\_ Late? \_\_\_\_\_\_ If early, how many weeks’ gestation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did mother have any illnesses or problems with her pregnancy?  Yes  No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ During pregnancy, did mother: Smoke  Yes  No Drink Alcohol  Yes  No Use drugs or medications  Yes  No What \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  Was the delivery  Vaginal Caesarean If Caesarean, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did your baby have any problems right after birth? * Yes  No Explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was initial feeding  Breast  Bottle Did your baby go home with mother from the hospital? * Yes  No Explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

General

|  |  |  |
| --- | --- | --- |
| Has your child had any broken bones, serious injuries, concussion?  |  Yes  No Explain:  |   |
| Does your child have any serious illness or medical condition?  |  Yes  No Explain:  |   |
| Has your child had any Emergency Room visits?  |  Yes  No Explain:  |   |
| Has your child had any operations or been hospitalized?  |  Yes  No Explain:  |   |
| Does your child take any medications or supplements? |  Yes  No Explain:  |   |
| Is your child allergic to any medicines, foods, bee stings, cats/dogs? |  Yes  No Explain:  |   |

Development

Are you concer

ned about your child’s physical development?



Yes



 No

Explain:

Are you concerned about your child’s mental or emotional development?



Yes



 No

Explain:

Are you concerned about your child’s attention span?



Yes



 No

Explain:

If your child is in school:

How is his/her behavior in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you concerned about your child’s school performance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has he/she failed or repeated a grade in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is he/she doing in academic subjects? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is he/she in a special or resource classes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **STONY BROOK PEDIATRICS PC, FAAP**  |

Family History

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Did/Do you or any of the child’s relatives have any of the following? (If YES, please identify relative)** | **Mother** | **Father** | **Siblings** | **Father’s****Parents** | **Mother’s Parents** |
| Allergies  |  |  |  |  |  |
| Asthma/Wheezing |  |  |  |  |  |
| Cardiac (heart) problems |  |  |  |  |  |
| Fainting |  |  |  |  |  |
| Sudden Death (before age 60)  |  |  |  |  |  |
| Stroke/Blood Clots |  |  |  |  |  |
| High cholesterol  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |
| Diabetes  |  |  |  |  |  |
| Obesity |  |  |  |  |  |
| Bleeding Tendency  |  |  |  |  |  |
| Cancer (Please specify type) |  |  |  |  |  |
| Scoliosis  |  |  |  |  |  |
| Dev Hip Dysplasia |  |  |  |  |  |
| Eczema or Psoriasis |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| Thyroid |  |  |  |  |  |
| Stomach or Intestinal problems |  |  |  |  |  |
| Kidney/Renal disease  |  |  |  |  |  |
| Migraines |  |  |  |  |  |
| Seizures |  |  |  |  |  |
| Hearing Loss |  |  |  |  |  |
| Vision problems |  |  |  |  |  |
| Mental retardation |  |  |  |  |  |
| Developmental delays |  |  |  |  |  |
| Autism |  |  |  |  |  |
| Sleep Disorder |  |  |  |  |  |
| School problem |  |  |  |  |  |
| Learning disability |  |  |  |  |  |
| ADHD |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Anxiety or OCD |  |  |  |  |  |
| Bipolar disorder/psychiatric problems |  |  |  |  |  |
| Alcoholism, drug use/addiction |  |  |  |  |  |
| Genetic (cystic fibrosis, hemophilia, Marfan syndrome, Leiden V mutation, neurofibromatosis etc. |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |
| Reaction to dyes or anesthesia |  |  |  |  |  |
| Chemical exposure (military or job related) |  |  |  |  |  |
| Immune problems, HIV or AIDS |  |  |  |  |  |

Any additional medical problems that run in the family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home type: House Apartment Mobile Home

Heating: Forced Air Hot Water/Radiator Wood/Pellet Stove Other

Drinking Water: Village Well Bottled

Flouride in drinking water? Yes No Unsure

Does your child spend time in a home built before 1970 or one recently remodeled ? Yes No

Are there guns in the Home ? Yes No If Yes how are they stored\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Pets? Yes No If Yes please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any cigarette smokers? Yes No If yes please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing any family or financial problems? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s History Does your child have, or has he/she ever had:

|  |  |  |  |
| --- | --- | --- | --- |
| Chickenpox  |  Yes  |  No  | When |
| Frequent ear infections  |  Yes  |  No  | Explain |
| Problems with ears or hearing  |  Yes  |  No  | Explain |
| Nasal allergies  |  Yes  |  No  | Explain |
| Problems with eyes or vision  |  Yes  |  No  | Explain |
| Asthma, bronchitis, bronchiolitis, or pneumonia  |  Yes  |  No  | Explain |
| Any heart problem or heart murmur  |  Yes  |  No  | Explain |
| Anemia or bleeding problem  |  Yes  |  No  | Explain |
| Blood transfusion  |  Yes  |  No  | Explain |
| Frequent abdominal pain  |  Yes  |  No  | Explain |
| Constipation requiring doctor’s visits  |  Yes  |  No  | Explain |
| Bladder / kidney infection  |  Yes  |  No  | Explain |
| Bed-wetting (after 5years old)  |  Yes  |  No  | Explain |
| (For girls) Has she started her menstrual periods?  |  Yes  |  No  | Explain |
| (For girls) Are there problems with her period?  |  Yes  |  No  | Explain |
| Any chronic or recurrent skin problem  |  Yes  |  No  | Explain |
| (acne, eczema, etc.)  |  |   | Explain |
| Frequent headaches  |  Yes  |  No  | Explain |
| Convulsions or other neurological problem  |  Yes  |  No  | Explain |
| Diabetes  |  Yes  |  No  | Explain |
| Thyroid or other endocrine problem  |  Yes  |  No  | Explain |
| Any other significant problem  |  Yes  |  No  | Explain |
| Use of alcohol or drugs  |  Yes  |  No  | Explain |