COLUMBIA UNIVERSITY MEDICAL CENTER

Welcome to Columbia Midtown Pediatrics! We're glad you are joining the practice. In order to give your child the best possible care, we will need detailed information about your child's and family's medical history. Please complete both sides of the form and sign the release at the end. Thank you.

Patient's Last Name _____ First name _____

Parent / Legal guardian(s) _____

STATEMENT: I hereby authorize the physician to release all medical information necessary to process insurance claims. I also agree to make monthly payments if a balance is due on my account.

Patient's authorized signature (parent if under 18): _____

BIRTH HISTORY

Which pregnancy is this child? _____

Is your child adopted? Y / N *If so, please describe the following to the best of your knowledge*.

Did the mother have any health problems during the pregnancy? Y / N

If yes, please describe _____

Hospital / city of birth _____ Any previous miscarriage? Y / N _____

If yes, reason? _____

Born by vaginal delivery or c/section? _____ If c/section, reason _____

How many months' gestation at birth? _____

Birth weight _____ APGAR score (if known) _____

Did the child leave the hospital with the mother? Y / N Length of hospital stay _____

If no, reason _____

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc)

_____

_____

_____

FAMILY HISTORY

Has any family member had any of the following illnesses? When answering these questions, please consider the child's **parents, grandparents, siblings, aunts and uncles**. Please specify which family member(s) when answering 'yes' to any question and provide any details you know.

			relationship to patient
Tuberculosis	Y	N	_____
Asthma	Y	N	_____
Allergies	Y	N	_____
Eczema	Y	N	_____
Other skin problems	Y	N	_____
Sinus problems	Y	N	_____
Cataract	Y	N	_____
Glaucoma	Y	N	_____
Blindness	Y	N	_____
Hearing Problem	Y	N	_____
Headaches/migraines	Y	N	_____
Stroke/aneurysm	Y	N	_____
Seizure/epilepsy	Y	N	_____
Hives/urticaria	Y	N	_____
Heart disease	Y	N	_____
High cholesterol	Y	N	_____
High blood pressure	Y	N	_____
Lactose intolerance	Y	N	_____
Celiac disease	Y	N	_____
Ulcers	Y	N	_____
Kidney stones	Y	N	_____
Kidney disease	Y	N	_____
Bleeding/bruising	Y	N	_____
Sickle cell disease	Y	N	_____
Anemia	Y	N	_____
Cancer/leukemia	Y	N	_____
Immune deficiency	Y	N	_____
Lupus	Y	N	_____
Osteoarthritis	Y	N	_____
Rheumatoid arthritis	Y	N	_____
Mental retardation	Y	N	_____
Psychiatric diagnosis	Y	N	_____
Thyroid problems	Y	N	_____
Diabetes	Y	N	_____

Other problems / illnesses _____

_____

_____

_____

CHILD'S HEALTH HISTORY (if your child is a newborn, you may skip this section)

How would you describe your child's health generally? _____

Is he/she taking any medications on a regular basis (please list with dose/frequency)? _____

_____

Is your child allergic to any medications? Y / N

If yes, what medicine and what type of reaction?_____

Has your child ever been admitted to the hospital? Y / N

if yes, date, reason, duration:_____

Has your child ever had surgery? Y / N

if yes, type, date and outcome:_____

Has your child had any major injuries? Y / N

if yes, date / description:_____

Has your child ever had any of the following illnesses or conditions? Please circle 'yes' or 'no' and provide dates / comments. If you answer 'yes' to any questions, please provide details at the end of this section.

			if yes, date				*if yes, date*
Asthma	Y	N		Colitis	Y	N	
Allergies (food)	Y	N		Chronic diarrhea	Y	N	
Allergies (seasonal)	Y	N		Lactose intolerance	Y	N	
Eczema	Y	N		Appendicitis	Y	N	
Other skin problem	Y	N		Hepatitis	Y	N	
Chickenpox	Y	N		Hernia	Y	N	
Scarlet fever	Y	N		Celiac disease	Y	N	
Pneumonia	Y	N		Ulcers	Y	N	
Tuberculosis	Y	N		Urine infections	Y	N	
Lyme Disease	Y	N		Kidney stones	Y	N	
Rheumatic fever	Y	N		Bleeding / bruising	Y	N	
Kawasaki Disease	Y	N		Sickle cell disease	Y	N	
Sinus problems	Y	N		Anemia	Y	N	
Vision problem	Y	N		Cancer / leukemia	Y	N	
Hearing problem	Y	N		Bone / joint problems	Y	N	
Ear infections	Y	N		Developmental / behavioral problems	Y	N	
Headaches	Y	N		ADHD	Y	N	
Head trauma	Y	N		Thyroid problem	Y	N	
Seizure / epilepsy	Y	N		Diabetes	Y	N	
Hives / urticaria	Y	N		Growth problem	Y	N	
Heart murmur	Y	N		Other problems			
Heart defect	Y	N					
High blood pressure	Y	N					
Reflux / heartburn	Y	N					

Please use this space to elaborate on any of the above conditions or let us know about any other issues.

Thank you. We're looking forward to getting to know you and your children.

Jennifer Kangas MD
Lauren Levine MD