STAMFORD HEALTH
Healing. Reimagined.

Affiliate: Columbia University College of Physicians and Surgeons
A Planetree Hospital
A Magnet® Recognized Hospital

Patient (Child) Name: ____ **Date of Birth:**________/________/________ **M** ____ **F**_____

Allergies (food, drugs or environment)	**Date of onset**	**Type of reaction**
____	_______________	_____________________________________
____	_______________	_____________________________________
____	_______________	_____________________________________

Current Medications: Name	**Dosage**	**Frequency**
____	_______________	_____________________________________
____	_______________	_____________________________________
____	_______________	_____________________________________

Major Medical problems (Hospitalizations, Surgeries, Etc.) ____

____

Family Medical History

On either side of the family, could you let us know if these conditions are present, and who has them. If the history is unknown, write an "U" next to the items. If you are unsure, put a "?".

Conditions:	**Who Might Have It.**
Early Heart Disease (sudden death, heart attack)	____
Elevated Cholesterol	____
Elevated Blood Pressure	____
Lung Problems (asthma, tuberculosis)	____
Allergies (drugs, food or seasonal)	____
Liver problems (hepatitis, cirrhosis)	____
Blood disorders (anemia, excessive bleeding, low platelet)	____
Kidney problems (stone, failure)	____
Digestive problems (colitis, ulcers, gastritis, celiac)	____
Neurological problems (seizures, migraines)	____
Thyroid gland problems	____
Diabetes (adult or juvenile)	____
Obesity	____
Emotional difficulties (depression, anxiety, OCD, panic)	____
Cancers	____
Congenital defects	____
Learning difficulties (ADD,PDD, Autism)	____
Substance use (alcohol, prescription or street drugs)	____

Social History

Who lives at home: (include all members)	____
Do you live in the following:	Apartment:________Condo:________Home:_____Other(specify)__________
List any pets you have:	____
Which of the follow do you have:	Well water ______ Town water______
Does anyone in the home use tobacco:	Yes ____ No____

Signature: ____ Relationship to Patient(s):_____________________________ Date: _______/ _______/_______