

Jessica Davis MD

The New Mom's Family Doctor

781 Hudson Avenue | PO Box 173 | Stillwater, NY 12170
phone: 877.664.6116 | email: DrJess@jessicadavismd.com

NAME:

DOB:

CHILD HEALTH HISTORY

ALLERGIES

Medication / Supplement / Food / Animal / Insect	Reaction?

CONCERNS

What do you hope to achieve by seeing Dr. Davis?

Please list any special issues or questions you would like to have addressed:

- 1)
- 2)
- 3)
- 4)

MEDICAL HISTORY

Medical Diagnosis / Problems / Injuries	New	Ongoing	Resolved	Date Started		Surgeries / Hospitalizations	Dates

Please use this space for any additional comments or explanation. Print out extras of this page if you need extra space.

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BIRTH HISTORY

Mom's health during pregnancy:

Full term / Pre-term

(how many weeks?) _____

Any complications or abnormal labor? Please describe:

Vaginal Delivery (unassisted / vacuum assisted / forceps assisted) / Cesarean

Any additional comments:

CURRENT MEDICATIONS & NUTRITIONAL SUPPLEMENTS (Herbs, Vitamins, Homeopathy, etc)

Medication/Supplement	Dose	Frequency	Reason for Use

Have medications or supplements ever caused unusual side effects? **Yes** **No**

Describe: _____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc), Motrin, Aspirin, Tylenol **Yes** **No**

Has your child had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) ? **Yes** **No**

Frequent antibiotics > 3 times/year? **Yes** **No**

Long term antibiotics **Yes** **No**

Use of steroids (prednisone, nasal allergy inhalers) in the past **Yes** **No**

Date of last physical?

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FAMILY HISTORY

Please check any family members who have the following health problems:

	Father	Mother	Brother	Sister	Grandparent	Other
Age (if still alive)						
OR Age at death						
Diabetes						
Glaucoma						
Colon Cancer						
Breast Cancer						
Ovarian Cancer						
Other Cancer						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Other Mental Illness						
Suicide						
Obesity						
Asthma						
Eczema/Psoriasis						
Food Allergies						
Autoimmune Disease						
Genetic Disorders						
Other health issues						

Is there a Family History of:

Heart Attack in a sister or mother before the age of 65 years of age? **Yes** **No**

Heart Attack in a brother or father before the age of 55 years of age? **Yes** **No**

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REVIEW OF SYSTEMS

Check the Yes or No column for any symptoms that are CURRENTLY a problem:

Yes	No	General	Yes	No	Dermatology	Yes	No	GI
		Fever			Rash			Nausea
		Chills			Itching			Vomiting
		Sweats			Dryness			Diarrhea
		Fatigue			Suspicious moles			Constipation
		Decreased appetite	Yes	No	Musculoskeletal			Change in bowel habits
		Weakness			Back pain			Abdominal pain
		Just don't feel well			Joint pain			Black or tar-like stools
		Weight loss			Joint swelling			Bloody stools
		Sleep problems			Muscle cramps			Gas/Bloating
Yes	No	Eyes			Muscle weakness			Indigestion/Heartburn
		Blurred vision			Restless legs			Difficulty Swallowing
		Double vision			Leg pain at night			Feel full early
		Eye discharge	Yes	No	Hematology	Yes	No	Neurology
		Vision change or loss			Unusual bruising			Paralysis
		Eye pain			Unusual bleeding			Unusual sensations
		Sensitivity to light			Swollen lymph nodes			Seizures
Yes	No	Ears/Nose/Throat	Yes	No	Psychiatric			Tremors
		Earache			Depression			Vertigo/Dizziness
		Ear discharge			Anxiety			Frequent falls
		Tinnitus/Ringing			Memory loss			Frequent headaches
		Decreased hearing			Suicidal Thoughts			Difficulty walking
		Nasal congestion			Hallucinations	Yes	No	Cardiovascular
		Hoarseness			Paranoia			Chest pains
		Nosebleeds			Phobia/Fear of things			Palpitations
Yes	No	Respiratory			Confusion			Skipped beats
		Cough			Trouble concentrating			Syncope/Fainting
		Difficulty breathing	Yes	No	Allergy			Difficulty breathing
		• at rest			Hives			• on exertion
		Excessive sputum			Frequent infections			• when lying down
		Wheezing			Itchy eyes			Shortness of breath at night
		Coughing up blood	Yes	No	Endocrinology			Swelling in your legs or ankles
		Pain with deep breath			Constantly cold	Yes	No	Reproductive
Yes	No	Urinary			Constantly hot			Vaginal bleeding
		Incontinence			Constantly thirsty			Missed periods
		Painful urination			Constantly hungry			Heavy periods
		Blood in the urine			Unusual weight change			PMS
		Genital sores			Frequent urination			Vaginal discharge

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GYNECOLOGIC HISTORY

MENSTRUAL HISTORY:

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: **Yes** **No**
Has your period ever skipped? **Yes** **No** For how long? _____
Last Menstrual Period: _____

IMMUNIZATIONS

Up to date? **Yes** / **No** If no, please explain (i.e. missed one, religious objection, alternative schedule, etc)

Please attach any immunization records.

SOCIAL HISTORY

Who lives at home with your child?

Parents:

Siblings (names and ages):

Other:

How many caffeinated drinks do your child have per day? (circle) **0 1 2 3 4+**

How many servings of soda does your child drink per day? (circle) **0 1 2 3 4+**

How many servings of water does your child drink in a day? **0 1 2 3 4+**

How many servings of milk does your child drink in a day? **0 1 2 3 4+**

How many meals does your family eat out per week? **0 1 2 3 4+**

How much prepared food does your child eat? (not home-made) - give approximate percent and list main foods:

If your child is on a special diet, or has certain restrictions, please explain:

Do you think your child's weight is healthy? **Yes** **No**

Typical Diet (list each meal and snacks):

Exercise (type, duration, frequency):

Smoking? (pack per day/wk)

Alcohol? (amount, frequency)

Other drugs?

School Problems? (past/current)

To the best of my knowledge, this is an accurate statement of my child's health:

Signature: _____ **Date:** ____ - ____ - ____

Print Name of person completing form: _____