Natural Pediatric Medicine, LLC – Dr. Robin Russell

536 Main Street, New Hartford, CT 06057

PO Box 46, Pine Meadow, CT 06061

(860) 909-1082 – Phone • (860) 238-4519 – Fax

Patient Health History

Last Name:_____First Name:_____Middle Name:_____

Date of Birth:_____Age:_____

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance

1._____

2._____

3._____

4._____

MEDICATIONS: Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

1._____ 4._____

2._____ 5._____

3._____ 6._____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1._____ 4._____

2._____ 5._____

3._____ 6._____

ALLERGIES: Please list Allergy and Reaction

1. Medication:_____

2. Environmental:_____

3. Food:_____

IMMUNIZATIONS HISTORY

□ Up to date

□ Partially Vaccinated:_____

_____

□ Unvaccinated

Last Name:_____First Name:_____DOB:_____

HOSPITALIZATIONS/SURGERIES

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCIES (IF APPLICABLE)

How many times have you been pregnant?_____
List ages of children:_____
Any complications with pregnancy or delivery?_____
Any miscarriages?_____
Any abortions?_____

LABS/EXAM HISTORY (IF APPLICABLE)

Date of last physical exam/Well Child Check:_____	Results: □ Normal □ Other _____
Date of last blood work:_____	Results: □ Normal □ Other _____
Date of last urine test:_____	Results: □ Normal □ Other _____
Date of last PAP:_____	Results: □ Normal □ Other _____
Date of last mammogram:_____	Results: □ Normal □ Other _____
Date of last DEXA scan:_____	Results: □ Normal □ Other _____
Date of last Colonoscopy:_____	Results: □ Normal □ Other _____

PERSONAL and FAMILY HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Autoimmune Disease									
Cancer									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Stroke									

Last Name:_____First Name:_____DOB:_____

PSYCHOSOCIAL HISTORY

Marital Status: □ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership
Siblings? □ No □ Yes - If Yes, please list their age(s)_____
Who does patient live with? □ Mother □ Father □ Siblings _____ □ Spouse □ Children_____ □ Other_____
Are you currently sexually active? □ No □ Yes
What form of contraception/birth control are you using (Check all that apply)?
□ Abstinence □ Withdrawal □ Fertility Awareness Method □ Condom □ Diaphragm □ IUD □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch □ Vasectomy □ Tubal Ligation □ None

TRAVEL HISTORY

Identify any domestic or foreign travel and indicate year of travel:

Place:_____ Year:_____ Place:_____Year:_____

PERSONAL HABITS

Which of the following substances do you use regularly?
□ Tobacco □ Alcohol □ Coffee/Tea □Recreational Drugs □ Other (Specify)_____

EXERCISE

Do you exercise regularly? □ Yes □ No
If you checked yes to exercising regularly, answer the following questions: What type?_____
How long?_____ How Often?_____

SLEEP

How many hours of sleep do you get at night on average?_____
Do you have any trouble falling asleep? □ Yes □ No
If yes, why?_____
Do you have difficulty staying asleep? □ Yes □ No
If yes, why?_____
Do you have trouble waking up? □ Yes □ No
If yes, why?_____
Do you wake rested? □ Yes □ No

ENERGY and STRESS

How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?_____
How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?_____

DIET

DIET PREFERENCE: □ No preference □ Ovo-Veg □ Lacto-Veg □ Lacto-Ovo-Veg □ Pescetarian □ Vegan □ Paleo □ Other_____
BREAKFAST:_____

_____

LUNCH:_____

_____

DINNER:_____

_____

SNACKS:_____

_____
WATER:_____