www.harmonymillspeds.com

Harmony Mills Pediatrics

(518) 233-9500

REQUIRED

Home & Family

Patient(s) Name(s) and Date(s) of Birth

Home Address

Mailing Address	Apt	City	State	Zip Code

Please list **every adult and child** living in the household, even if they are only there some of the time. Families can be complex, but accurate information will help us build a correct family history for every patient!

Name	Date of Birth	Relationship in family	Is this person a patient of Harmony Mills Pediatrics?
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

Please list the phone numbers we can use to contact your family, in order of preference (at least one number is required). Please note that **the first number you provide will be used for all appointment reminder calls!**

Phone number	Whose number is this?	What type of phone is this?
		◯ Mobile ◯ Home ◯ Work
		◯ Mobile ◯ Home ◯ Work
		◯ Mobile ◯ Home ◯ Work

Please list any email addresses we can use to contact your family. If you put an address in the first row of the chart (the shaded row), we may also email appointment reminders to you at that address.

Email address	Whose address is this?	Type of email?
		◯ Personal ◯ Work
		◯ Personal ◯ Work

Please indicate your preferred pharmacy. Any scripts written for patients in this home will be sent electronically to this pharmacy unless we are specifically instructed to send them to a different one.

Pharmacy Name	Address	Phone

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Biological Family Medical History

Please note that this form is for clinical purposes ONLY, and has no bearing whatsoever on physical or legal custody, access to medical records, or any other issue regarding the guardianship of your child. It is meant solely to keep our providers as informed as possible about how to care for your child.

		For which child(ren) in this practice is this a biological parent?
Biological Parent:		
Biological Parent:		
Biological Parent:		

Please indicate the **parent** ("Jim", "Mary "), or **any of their immediate relatives** ("Jim's brother", "Mary's mother", etc.), who has or has had any of the following problems.

Medical Problem	Who has or had this problem?	No known relative with this problem
○ Breathing problems, asthma, emphysema, tuberculosis, allergies		
○ Cancer		
○ Diabetes		
○ Heart attack, stroke, high blood pressure		
○ High cholesterol		
○ Visual Problems		
○ Hearing problems, deafness, speech problems		
○ Learning disability, intellectual disability, attention deficit disorder		
○ Mood disorder, depression, mania, bipolar		
○ Frequent headaches (tension, migraine), hydrocephalus		
○ Bleeding problems, hemophilia, sickle cell anemia		
○ Bone or Muscle Problem		
○ Stomach problems, ulcer, reflux		
○ Genetic Diseases such as Downs, Cystic Fibrosis, Huntington's Chorea, cerebral palsy, muscular dystrophy		
○ Seizures		
○ Thyroid problems		
○ Medical or food allergies		
○ Kidney or liver problems		
○ Other_____		