



GOTTESMAN MEDICAL PC
PEDIATRICS
555 LEFFERTS AVE
BROOKLYN, NY 11225

MEDICAL HISTORY FORM

Patient Name _____

DOB _____

Significant Medical History _____

MEDICATIONS () Yes () No

MEDICATION	DOSE	TIMES PER DAY

ALLERGIES () Yes () No

ALLERGIES	ALLERGIC REACTION

SURGERIES OR HOSPITALIZATIONS () Yes () No

DATE	SURGERIES	HOSPITALIZATIONS

FAMILY MEDICAL HISTORY

SIBLINGS: BROTHERS _____ SISTERS _____ SIGNIFICANT MEDICAL HISTORY _____

	DOB	AGE	HEART DISEASE	DIABETES	HIGH BLOOD PRESSURE	OTHER
FATHER						
MOTHER						

If Other, Please Specify _____