Legacy PEDIATRICS

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www.legacypeds.com

Patient Medical History – Required for all patients

Patient Name: _____ **DOB:** _____

Does your child have ANY medication or food allergies? _____

If so, what is the reaction? _____

List any medications your child is taking and include dosage and how taken (i.e. tablet, syrup):

_____

Hospitalizations: _____

Family History	Check		Maternal/Paternal Relationship Examples: Mom, Dad, Maternal Grandma, Paternal Grandpa
	Yes	No	
Anemia			
Arthritis			
Asthma			
Autism			
Autoimmune Disorder			
Cancer, Type:			
Diabetes, insulin dependent			
Heart Attack under age 50			
High Cholesterol			
Hypertension			
Kidney Disorder			
Psychiatric Illness			
Seasonal Allergies			
Sudden Death			
Other:			
Other:			

Patient Past History	Check	
	Yes	No
Allergies		
Anemia		
Asthma		
Autism		
Bed Wetting		
Cellulitis		
Chickenpox		
Constipation		
Down's Syndrome		
Eczema		
Fracture History		
Frequent Ear Infections		
GERD (reflux)		
Learning Disabilities		
Migraines		
Murmur		
Sickle Cell		
Sleep Apnea		
Snoring		
Strep Throat		
Tuberculosis		
UTIs		
Other:		
Other:		

Surgical History	Check		
	Yes	No	Year
PET's (tubes)			
Adenoidectomy			
Tonsillectomy			
Other:			

Social History	Check	
	Yes	No
Is Child in daycare?		
Do you use a car seat?		
If under age 1 or under 20lbs, is car seat rear facing?		
Does Child have good bedtime habits?		
Does anybody smoke in household?		
Has child or anyone in household traveled out of the country?		
If so, where to? :		
Parent's Occupation – Mom: Dad:		

Birth History	
Gestational Age	
Delivery Weight	
Type of Delivery	
Breast Fed	
How Long?	
Formula	
Water Supply	
Fracture History	
Normal Newborn Screening ☐Yes ☐No	