LEGACY
FAMILY MEDICINE, P.C.

PEDIATRIC/ADOLESCENT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex: ◯ M ◯ F Birthdate: _____

CHILD'S BIRTH HISTORY

(To be completed for patients that are one year of age or less, or if long-term medical problems are present)

How long was your pregnancy? _____ weeks
How was the baby born? ◯ Natural (Vaginal) ◯ C-Section If C-Section, reason: _____
Baby's weight at birth? _____ lbs _____ oz; Length? _____ inches
Name of the Hospital where baby was born: _____ Condition at birth? _____

During your pregnancy did you:

	Yes	No	Explain
Have high blood pressure?			
Have protein in your urine?			
Have German measles?			
Frequently smoke?			
Use Drugs?			
Have sugar in your urine?			
Have urinary tract infections?			
Take prescription medications?			
Have sexually transmitted disease?			
Drink Alcohol?			
Where there any other problems during pregnancy?			

MEDICAL HISTORY/ REVIEW OF SYSTEMS

Was your child ever diagnosed with, or has had:

___ birth defects
___ delayed development/growth
___ attention problems
___ diabetes
___ aggression
___ vision problems
___ sinus problems
___ hay fever
___ allergies
___ frequent nosebleeds
___ cough
___ asthma
___ heart problems
___ eating problems
___ diarrhea
___ weight problems
___ thyroid problems
___ difficulty sleeping
___ constipation
___ diabetes
___ cancer
___ kidney problems
___ bladder problems
___ bedwetting
___ seizures
___ headaches
___ skin problems
___ bruises/bleeds easily
___ anemia
___ frequent infections
___ teeth/gum problems
___ joint/muscle problems
___ pain (where_____)
___ other _____

Hospitalizations/Accidents:

_____
_____
_____

Medications:

_____
_____
_____

Allergies: (name of medication and reaction)

_____
_____
_____

Latex/Tape Allergies? ◯ Yes ◯ No

Immunizations:

◯ Up – To – Date ◯ Delayed/not given

(SEE REVERSE)

PEDIATRIC HEALTH HISTORY CONTINUED

Patient Name _____ Birthdate: _____

HEALTH RISK ASSESSMENT

(Please check all that apply to patient)

___ wears bike helmet
___ wears knee/elbow pads
___ seat belt/carseat use
___ has healthy eating habits
___ exercises regularly
___ drinks alcohol
___ is sexually active
___ uses drugs
___ has severe mood swings
___ is appropriately concerned for personal safety
___ smokes/smokers in the house
___ lives in (or often visits) house built in 1978 or earlier

FAMILY HISTORY

(If relatives have had any of these conditions, please check the appropriate box)

	Mother	Father	Siblings (please specify)	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather
Allergies							
Birth Defects							
Blood Disease							
Bone or joint disorder							
Cancers or Malignancies							
Asthma, chronic bronchitis							
Eye/ear disorders							
Diabetes							
Heart Problems							
Kidney or Bladder Disease							
Mental Retardation							
Muscular weakness/poor control							
Cerebral Palsy/Epilepsy							
Psychiatric Condition							
Rheumatic Fever							
Tuberculosis							
Sexually Transmitted Disease							
Thyroid Problems							
Other (Explain_____)							

SOCIAL HISTORY

Patient (child) lives with:

___ Parents
___ Mother
___ Other:_____
___ Parents and Siblings
___ Father

Patient Attends:

___ Day Care
___ School

What pets do you have in your house:

_____
_____
_____

Others Concerns:

_____
_____
_____
_____

Physician's Notes:

_____
_____
_____
_____
_____

Signature of Parent/Legacy Guardian: _____ **Date:** _____

Physician Signature: _____ **Date:** _____