Legacy Family Medicine, P.C.

PEDIATRIC/ADOLESCENT PATIENT HISTORY

1. IDENTIFICATION DATA (PLEASE PRINT)

Patient Name: (last, first, middle initial) _____

Birthdate: _____ / _____ / _____ Sex: ☐ Male ☐ Female

2. CHILD'S BIRTH HISTORY

(to be completed for patient one year of age or less, or if long-term medical problems 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 hospital where baby was born: _____ Condition at birth? _____

During your pregnancy did you:

Have high blood pressure?	☐ Y	☐ N	
Have protein in urine?	☐ Y	☐ N	
Have German measles?	☐ Y	☐ N	
Frequently smoke?	☐ Y	☐ N	
Use drugs?	☐ Y	☐ N	If yes, explain _____
Have sugar in urine?	☐ Y	☐ N	
Have urinary tract infection?	☐ Y	☐ N	
Take prescription medications?	☐ Y	☐ N	
Have a sexually transmitted disease?	☐ Y	☐ N	If yes, explain _____
Drink alcohol?	☐ Y	☐ N	If yes, explain _____
Were there any other problems during pregnancy?	☐ Y	☐ N	If so, what? _____

3. MEDICAL HISTORY/REVIEW OF SYSTEMS

Was your child ever diagnosed with or has had:

- ☐ birth defects
- ☐ delayed development/growth
- ☐ attention problems
- ☐ depression
- ☐ 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 allergy? ☐ Y ☐ N

Immunizations: ☐ up-to-date ☐ delayed/not given

See Reverse Side

Patient Name:

Date of Birth:

4. HEALTH RISK ASSESSMENT (PLEASE CHECK ALL THAT APPLY TO PATIENT)

- ☐ Wears bike helmet
- ☐ Wears knee/elbow pads
- ☐ Seat belt use
- ☐ Has healthy eating habits
- ☐ Exercises regularly
- ☐ Drinks alcohol
- ☐ Is sexually active
- ☐ Uses drugs
- ☐ Has severe mood swings
- ☐ Is approriately concerned for personal safety
- ☐ Smokes/Smokers in house
- ☐ Lives in (or often visits) house built in 1978 or earlier

5. FAMILY HISTORY

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

	Mother	Father	Sister/Brother	Sister/Brother	Sister/Brother	Mother's mother	Mother's father	Father's mother	Father's father	Other family members - mother's side	Other family members - father's side
Age/Health Status*											
Allergies											
Birth defects											
Blood disease											
Bone or joint disorders											
Cancers or malignancies											
Asthma, chonic bronchitis											
Eye/ear disorders											
Diabetes or thyroid disease											
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:_____)											

*** Health Status**
G - good
P - poor
D - age at death

6. SOCIAL HISTORY

Patient (child) lives with:

- ☐ Parents
- ☐ Parents and siblings
- ☐ Mother
- ☐ Father
- ☐ Other: _____

Patient attends:

- ☐ Day Care
- ☐ School

What pets do you have in your house? ☐ Not Applicable

_____

_____

Other Concerns:

_____

_____

_____

_____

Physician's Notes:

_____

_____

_____

_____

_____ **Date:** ____ / ____ / ____

Signature of Parent/Legal Guardian

_____ **Date:** ____ / ____ / ____

Signature of Physician

Patient Name:

Date of Birth: