NEW PATIENT
Past Medical History Form

Patient name_____**Age**_____**Birth Date**_____**Today's Date**_____

Parent(s) name_____**Siblings Names**_____

Answer below if you are a NEW patient to LPG (but not a newborn).

YES	NO	**Past Records**
☐	☐	Did you bring a copy of your child's immunization record?
☐	☐	Are they up to date on shots? If no, explain:
☐	☐	Are medical records being sent from your previous doctor?
		Who was the most recent physician?

Birth History and Infancy

Birth weight:

Check the box if any of these things are true:

☐pregnancy or delivery complications – explain:

☐complications after birth (special tests or procedures) – explain:

☐feeding issues – explain:

Breastfed for months

Sat alone at age Walked alone at age

Which side of the family? MOM's	DAD's	**Family History:** List the relationship to the child next to the condition. (siblings, parents, grandparents, aunts/uncles, cousins)
☐	☐	Asthma
☐	☐	Allergies / hay fever
☐	☐	Eczema
☐	☐	Lead poisoning
☐	☐	Developmental disabilities
☐	☐	Seizures
☐	☐	Stillborn babies or miscarriages
☐	☐	Birth defects
☐	☐	Hearing loss
☐	☐	Kidney disease
☐	☐	Blood or bleeding disorders
☐	☐	Cancer
☐	☐	Thyroid disease
☐	☐	Diabetes
☐	☐	Heart disease
☐	☐	High blood pressure
☐	☐	High cholesterol
☐	☐	Strokes
☐	☐	Tuberculosis
☐	☐	Depression or Anxiety
☐	☐	Mental illness
☐	☐	Alcoholism
☐	☐	Drug addiction
☐	☐	Other inherited diseases

Are you here for a well child check-up/physical? ☐YES → stop here. ☐NO → continue to the other side.

New Patient Past Medical History

YES	NO	
☐	☐	Are you here for a well child check-up/physical? If YES, don't answer the questions below. You'll be directed to complete a well child questionnaire based on age, which will gather this info.
YES	NO	
☐	☐	Are you here for a problem or sick visit? If YES, continue below. We want to know more about you.
☐	☐	Does your child visit a specialty doctor regularly? If yes, enter information. Problem or Diagnosis: Physician: Next scheduled visit:
YES	NO	
☐	☐	Has your child had surgery? Procedure: Age: Physician:
YES	NO	
☐	☐	Has your child had a seizure, major injury or a hospitalization? Reason: Age: Hospital:
YES	NO	
☐	☐	Does your child take medications or vitamins on a regular or daily basis? List drugs and reasons:
YES	NO	
☐	☐	Are there drug allergies? To what?
☐	☐	Does anyone smoke in your child's environment? Who?
YES	NO	
☐	☐	Have you had concerns about any of the following things: ☐allergies ☐food allergy or intolerance ☐eczema ☐hives ☐wheezing or asthma ☐constant cold or runny nose ☐recurrent ear infections ☐recurrent sore throats ☐diarrhea ☐constipation ☐obesity ☐poor appetite ☐vision ☐hearing ☐teeth ☐sleep ☐toilet training ☐speech delay ☐school achievement ☐getting along with others