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 (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:
		Who was the most recent physician / healthcare provider?
☐	☐	Are medical records being sent from your previous doctor?
		If no, you will need to sign a consent form so we can get the records transferred to LPG.

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____

Are you here for a well child check-up / physical?

If YES, stop here! If NO, continue below!

YES	NO	
☐	☐	Does your child visit a specialty doctor regularly? If yes, enter information.
		Physician:
		Problem or Diagnosis:
		Next scheduled visit:
☐	☐	Has your child had surgery?
		Procedure: Physician: Age:
☐	☐	Has your child had a seizure, major injury, or stayed overnight in a hospital?
		Hospital: Reason: Age:
☐	☐	Does your child take medications or vitamins on a regular or daily basis?
		List drugs and reasons:
☐	☐	Are there drug allergies? To what?
☐	☐	Does anyone smoke in your child's environment? Who?
☐	☐	Have you had concerns about any of the following things:

☐allergies	☐recurrent ear infections	☐vision	☐school achievement
☐food allergy or intolerance	☐recurrent sore throats	☐hearing	
☐eczema	☐diarrhea	☐teeth	☐getting along with others
☐hives	☐constipation	☐sleep	
☐wheezing or asthma	☐obesity	☐toilet training	
☐constant cold or runny nose	☐poor appetite	☐speech delay	