LEGACY MEDICAL CARE

Medical History

First Name: _____ Last Name: _____ Date of Birth: _____

Current Medications: (Include dose (amount) per day)

Medications	Dose	Frequency

Drug Allergies: ☐ Yes ☐ No
List:_____

Surgical History: ☐ Yes ☐ No

Date	Surgeries

Hospitalization: ☐ Yes ☐ No

Date Arrived	Discharged Date	Reason

Social History:
Do you smoke/use tobacco? ☐ Yes ☐ No If the answer is yes: How many packs a day? _____
Do you use tobacco using different method? ☐ Yes ☐ No If the answer is yes: How much a day? _____

Do you use drugs? ☐ Yes ☐ No If the answer is yes: What kind_____ How often? _____

Do you drink alcohol? ☐ Yes ☐ No If the answer is yes: How often? _____

Do you consume caffeine? ☐ Yes ☐ No If the answer is yes: How often? _____

Do you exercise? ☐ Yes ☐ No If the answer is yes: How often? _____

How much screen time a day do you have?_____ How often? _____

Have you ever been or are currently sexually active? ☐ Yes ☐ No

Birth Hospital (New Born patients only):
☐ Alexian Brothers Hospital ☐ Northwest Community Hospital ☐ Sherman Hospital ☐ St.Alexius Hospital

☐ Central DuPage Hospital ☐ Other: _____

Family History: Please mark an "X" to indicate the answer is yes.

	Living	Deceased	Unknown	Year of Birth		Asthma	Cancer	Diabetes	Heart Disease	Hypertension	Mental Illness	Migraine	Stroke	Unknown	Other
Daughter															
Son															
Spouse															
Mother															
Father															
Paternal Grand Father															
Paternal Grand Mother															
Maternal Grand Father															
Maternal Grand Mother															
Brother															
Sister															
Other:															
Other:															

GYN/ OB History (Please complete the following section if you are a Female)

What is the day of your last menstrual cycle? _____ At what age did you start your menstrual cycle? _____

Have you had a pap smear done? □ Yes □ No If the answer is yes: What is the date of your last pap smear? ___

How often do you get your period? _____ How many days is your period? _____

Are you on birth control? □ Yes □ No If the answer is yes what kind? _____

Have you had a mammogram? □ Yes □ No If the answer is yes what is the date? _____

Pregnancy History (All pregnancies) □ **Have never been pregnant**

Obstetrical history including abortions & ectopic pregnancies

					Child Information		
Year	**Place of delivery or Abortion**	**Duration Preg. (Wks)**	**Type of Delivery**	**Complications Mother and/or Infant**	**Sex**	**Birth Weight**	**Present Health**