

Frank J. Liggio, MD

Medical History Form

Patient's Name:

D.O.B.:

Mother's Pregnancy: (check all that apply)

Premature (<36 weeks) yes no Breech Presentation: yes no

C-section: yes no

Adopted: yes no

Patient's Development: (check all that apply)

Motor Skills age appropriate: yes no

Speech age appropriate: yes no

Requires: OT X/week, PT X/week, Speech Therapy X/week

Assistive devices: (if needed) _____

Patient's Medical History: (check all that apply)

History of illness:

Asthma Cerebral Palsy Bronchopulmonary Dysplasia Dev.

Delay Diabetes Gastrointestinal Disease Heart Disease

Hydrocephalus Intraventricular Hemorrhage Kidney Disease

Seizures Strabismus Other:

Immunizations up to date: yes no

Allergies:

No Drug Allergies Cephalosporin Iodine Latex Penicillin

Shellfish Sulfa Medications Other:

Describe what happens:

Past surgeries:

None Appendectomy Ear Tubes Fracture Repair Hernia

Hip Surgery Soft Tissue Lengthening Spine Fusion

Tonsillectomy/Adenoidectomy VP Shunt Other:

Family History: (check all that applied)

Asthma Bowed Legs Heart Disease Hip Dysplasia

In toeing Scoliosis Other:

Medications:

Medication and Strength

How is This Medication Taken

Medication and Strength	How is This Medication Taken