



**LANDMARK INTERNAL MEDICINE**

**7615 Clarington Cove,**

**Southaven, MS 38671**

**Phone: (662) 536-2500**

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**Medical History**

Check all that the patient has experienced and year and month of onset

___ Allergies	Mo/Yr
___ Food allergies	___/___
___ Animal allergies	___/___
___ Seasonal allergies	___/___
___ Medication allergy	___/___
___ Insect allergies	___/___
___ Other allergies	___/___
___ Anemia	___/___
___ Asthma	___/___
___ Autoimmune diseases	___/___
___ Birth difficulties	___/___
___ Blood disorders	___/___
___ Bone disease	___/___
___ Cancer	___/___
___ Celiac disease	___/___
___ Cerebral Palsy	___/___
___ Constipation	___/___
___ Cystic fibrosis	___/___
___ Eczema	___/___
___ Endocrine or hormonal problems	___/___
___ Eosinophilic Esophagitis	___/___
___ Food Intolerance	___/___
___ Gastroesophageal Reflux	___/___
___ Genetic disorders	___/___
___ Growth issues	___/___
___ Heart disease	___/___
___ Hearing problems, or wears hearing aids	___/___
___ Hernia	___/___
___ Immune deficiency	___/___
___ Joint pain	___/___

- Kidney disease \_\_\_\_/\_\_\_\_
- Migraine headaches \_\_\_\_/\_\_\_\_
- Prematurity \_\_\_\_/\_\_\_\_
- Scoliosis \_\_\_\_/\_\_\_\_
- Seizure \_\_\_\_/\_\_\_\_
- Sleep disturbances \_\_\_\_/\_\_\_\_
- Stroke \_\_\_\_/\_\_\_\_
- Thyroid problems \_\_\_\_/\_\_\_\_
- Vision problems, or wears eye glasses \_\_\_\_/\_\_\_\_
- Chronic vomiting \_\_\_\_/\_\_\_\_
- Weight issues \_\_\_\_/\_\_\_\_

***Developmental and Psychiatric History***

**Mo/Yr**

- ADHD \_\_\_\_/\_\_\_\_
- Anxiety \_\_\_\_/\_\_\_\_
- Autism \_\_\_\_/\_\_\_\_
- Aggression/Irritability \_\_\_\_/\_\_\_\_
- Conduct disorder \_\_\_\_/\_\_\_\_
- Depression \_\_\_\_/\_\_\_\_
- Developmental Delays \_\_\_\_/\_\_\_\_
- Eating disorder \_\_\_\_/\_\_\_\_
- Feeding difficulties \_\_\_\_/\_\_\_\_
- Learning disorders \_\_\_\_/\_\_\_\_
- Oppositional Defiant Disorder \_\_\_\_/\_\_\_\_
- Self harm or cutting \_\_\_\_/\_\_\_\_
- Substance abuse \_\_\_\_/\_\_\_\_
- Suicide attempt or ideation \_\_\_\_/\_\_\_\_
- Tourette's Syndrome \_\_\_\_/\_\_\_\_
- Other \_\_\_\_\_ \_\_\_\_/\_\_\_\_

***Services and Therapy Interventions Received***

- Individualized Education Plan (IEP) in school. \_\_\_\_/\_\_\_\_
- 504 Plan in school \_\_\_\_/\_\_\_\_
- Early Intervention Services in early childhood. \_\_\_\_/\_\_\_\_
- Individualized Family Service Plan (IFSP) \_\_\_\_/\_\_\_\_
- Speech therapy \_\_\_\_/\_\_\_\_
- Occupational therapy \_\_\_\_/\_\_\_\_
- Physical therapy \_\_\_\_/\_\_\_\_
- Psychotherapy \_\_\_\_/\_\_\_\_
- Applied Behavioral Analysis (ABA) \_\_\_\_/\_\_\_\_
- Respite Care \_\_\_\_/\_\_\_\_

**Surgeries**

<input type="checkbox"/> Circumcision (if applicable)	_____ / _____
<input type="checkbox"/> Adenoidectomy	_____ / _____
<input type="checkbox"/> Tonsillectomy	_____ / _____
<input type="checkbox"/> Appendectomy	_____ / _____
<input type="checkbox"/> Ear surgery	_____ / _____
<input type="checkbox"/> Bowel resection	_____ / _____
<input type="checkbox"/> Heart surgery	_____ / _____
<input type="checkbox"/> Hernia repair	_____ / _____
<input type="checkbox"/> Surgery for fractures	_____ / _____
<input type="checkbox"/> Other surgery, please specify _____	_____ / _____

Please list hospitalizations with reason for hospitalization, and admission and discharge dates:

Reason for hospitalization	Admission date	Discharge date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Social History**

Ethnicity:  Hispanic or Latino  Non-Hispanic or non-Latino  
 Parents' Relationship:  Married  Divorced  Widowed  Single  Separated  
 Patient resides with:  
 Primary  Mother  Father  Both Parents  Other  
 Secondary  Mother  Father  Both Parents  Other  Not Applicable  
 Number of brothers who live in the home: \_\_\_\_\_  
 Number of sisters who live in the home: \_\_\_\_\_  
 Number of siblings who no longer live at home: \_\_\_\_\_

Childcare:  Mother  Father  Grandparent/s  Nanny  Daycare  Other

Tobacco Exposure  Yes  No      Smokers at Home  Yes  No

Pets  Yes  No; If yes, please specify: \_\_\_\_\_

International travel to:      1) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_  
    2) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_  
    3) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_

**Medication History**

Name	Strength	Form	# of times/day
For example			



Mental illnesses as follows:

Suspected or known ADHD

\_\_\_\_\_

Suspected or known autism

\_\_\_\_\_

Anxiety

\_\_\_\_\_

Bipolar disorder

\_\_\_\_\_

Depression

\_\_\_\_\_

Suicidal attempt

\_\_\_\_\_

Eating disorder

\_\_\_\_\_

Substance abuse

\_\_\_\_\_

Anything else we should be aware of regarding the patient: \_\_\_\_\_

\_\_\_\_\_