

## Pediatric Medical History Form

**Patient Full Name:** \_\_\_\_\_ **Date of Visit:** \_\_\_\_\_ **OC#:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Height :** \_\_\_\_\_ **Weight:** \_\_\_\_\_  
**Provider Name:** \_\_\_\_\_ **Pharmacy and Phone #:** \_\_\_\_\_  
**Who is your Primary Care Provider?** \_\_\_\_\_ **Who referred you to our office?** \_\_\_\_\_

### Reason for Visit

**Please describe the reason for today's visit:** \_\_\_\_\_ **Date Problem Began:** \_\_\_\_\_

**If visit is related to an injury, how did the injury occur?**  No injury  
 Fall  Sports / Recreation  Motor vehicle accident  Other: \_\_\_\_\_

### Medical History

- None OR Check all that apply (Use *other\** if problem not listed)**
- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Blood Clots               | <input type="checkbox"/> Pregnancy     |
| <input type="checkbox"/> Club Foot            | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Sickle Cell Trait/Disease | <input type="checkbox"/> Depression    |
| <input type="checkbox"/> Delay in Development | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Drug Abuse    |
| <input type="checkbox"/> Trouble Walking      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder          | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> ADD/ADHD      |
| <input type="checkbox"/> Spina Bifida         | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> HIV/AIDS      |
| <input type="checkbox"/> Hip Dysplasia        | <input type="checkbox"/> Cystic Fibrosis     | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> MRSA          |
| <input type="checkbox"/> Autism               | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Type: _____               | <input type="checkbox"/> Other*: _____ |

**List Drug/Food Allergies and Reaction:**  None  Yes If yes, please list: \_\_\_\_\_

**List Current Medications:** (Please include prescriptions, vitamins or over the counter medications patient is currently taking:

None  Yes If yes, please list: \_\_\_\_\_

**List Any Past Surgeries and Date:**  None  Yes If yes, please list: \_\_\_\_\_

### Family History

- None**  **Unknown/Adopted** **OR indicate if any of the patient's blood relatives have had any of the following conditions, check the box. (Use *other\** if problem not listed.)**
- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Hip Dysplasia         | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Club Foot            | <input type="checkbox"/> Autism                | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Gastrointestinal Disease |
| <input type="checkbox"/> Delay in Development | <input type="checkbox"/> Cerebral Palsy        | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Kidney Problems          |
| <input type="checkbox"/> Trouble Walking      | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Blood Disorders  | Type: _____                                       |
| <input type="checkbox"/> Spina Bifida         | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Diabetes         |   |
| <input type="checkbox"/> Other*: _____        |  |   |   |

### Social History

**Lives at home with:** \_\_\_\_\_ **Grade in School:** \_\_\_\_\_  
**Tobacco Use:**  Yes  No **Alcohol Use:**  Yes  No **Current or Past Drug Abuse:**  Yes  No

### General Health

**In the past 3 months has the patient had:**  Fever  Rash  Infection  Required Medication  
**Has the patient had problems with the same orthopedic problem they are being seen for today?**  Yes  No  
**If yes, please explain:** \_\_\_\_\_

**Does the patient have a current problem with any of the following:** (circle "Y" for yes, "N" for no)

Recent Weight Change	Y N	Headaches	Y N	Painful Urination	Y N	Arthritis	Y N
Difficulty Breathing	Y N	Chronic cough	Y N	Dizziness	Y N	Convulsions	Y N
Excessive thirst	Y N	Dry Skin	Y N	Difficulty Walking	Y N	Sleep Disturbances	Y N
Bleed Easily	Y N	Depression	Y N	Loss of Hearing	Y N	Decreased Appetite	Y N
Bruise Easily	Y N	Worsening Vision	Y N	Vomiting	Y N	Abdominal Pain	Y N

**Has the patient had any of the following tests/procedures related to this problem? If yes, check and provide date.**

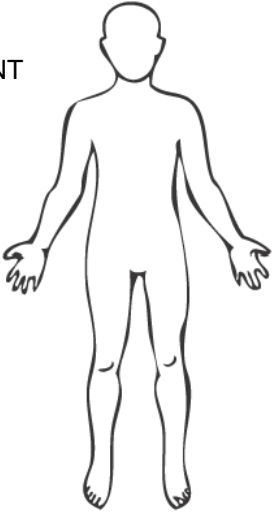
- |                                    |           |   |           |  |           |
|------------------------------------|-----------|---|-----------|--|-----------|
| <input type="checkbox"/> X-ray     | ____/____ | <input type="checkbox"/> Physical Therapy | ____/____ | <input type="checkbox"/> Pain Management | ____/____ |
| <input type="checkbox"/> Myelogram | ____/____ | <input type="checkbox"/> CAT Scan         | ____/____ | <input type="checkbox"/> MRI             | ____/____ |
| <input type="checkbox"/> Lab Work  | ____/____ | <input type="checkbox"/> Bone Scan        | ____/____ | <input type="checkbox"/> EMG/NCV         | ____/____ |

## Pediatric Center Patient Worksheet

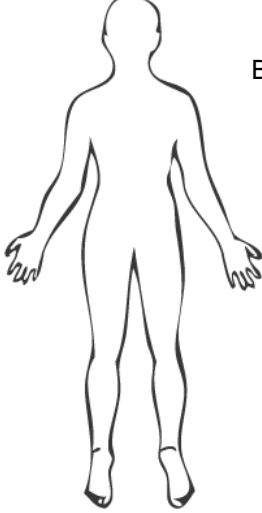
Date of Visit: \_\_\_\_\_ Patient Full Name: \_\_\_\_\_ OC # \_\_\_\_\_

**Please mark an "X" to indicate the location of your pain;**

FRONT



BACK



***IF YOUR CHILD IS BEING SEEN FOR AN INJURY OR TRAUMA (BROKEN BONE, SPRAIN, SPORTS INJURY, ETC) IT IS NOT NECESSARY TO COMPLETE THE FOLLOWING QUESTIONS.***

### Birth and Developmental History

Weeks gestation: \_\_\_\_\_ wks    Birth weight: \_\_\_\_\_    Type of delivery:  Vaginal     Cesarean     Breech  
 Complications with pregnancy or delivery:    None \_\_\_\_\_  
 This is my  1st     2nd     3rd     4th     5th     Other \_\_\_\_\_ born child.  
 Age child sat independently: \_\_\_\_\_ months    Age child walked independently: \_\_\_\_\_ months  
 Does your child have any physical or mental disabilities?  No     Yes    If yes, please describe: \_\_\_\_\_

### Special Needs Children

Does your child wear orthotics?  No     Yes    If yes, please specify:  AFO     SMO     DAFO     HKAFO     Shoe Lift  
 Other: \_\_\_\_\_  
 Does your child attend any type of therapy?  No     Yes    If yes, please specify:  PT     OT     ST  
 Other: \_\_\_\_\_  
 Does your child walk independently?  Yes     No    If no, please specify the type of assistance required:  
 Wheelchair     Stander     Reverse Walker     Lofstrand Crutches     Other \_\_\_\_\_  
 Does your child communicate verbally?  Yes     No    If no, please specify the method of communication: \_\_\_\_\_

### Scoliosis Patients

Who noticed the curve?  Parent     Patient     Physician     School Representative     Other: \_\_\_\_\_  
 Is there a family history of scoliosis?  No     Yes    If yes, please indicate relative: \_\_\_\_\_  
 If female, please indicate the date of first menstrual cycle: \_\_\_\_\_  
 Does the patient have back pain?  No     Yes

**For Office Use Only:**

Date Reviewed	Change? Y or N	Clinical Staff	Provider		Date Reviewed	Change? Y or N	Clinical Staff	Provider
_____	_____	_____	_____		_____	_____	_____	_____