

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 Condition

- [] None OR write "P" for Past and "C" for Current
[] ADD [] Cancer: type _____ [] Drug Abuse [] MRSA
[] ADHD [] Cerebral Palsy [] Dysplasia of Hip [] Pregnancy
[] Alcohol Abuse [] Club Foot [] Heart Disease/Defect [] Scoliosis
[] Anemia [] Cystic Fibrosis [] High Blood Pressure [] Seizures
[] Arthritis [] Delay in Development [] High Cholesterol [] Sickle Cell Trait
[] Asthma [] Depression [] HIV/AIDs [] Sickle Cell Disease
[] Autism [] Diabetes [] Kidney Problems [] Spina Bifida
[] Blood Disorders [] Difficulty Walking [] Liver Disease [] Thyroid Disease
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 all that apply. (Use other* if problem not listed.)
[] Anemia [] Club Foot [] High Blood Pressure [] Seizures
[] Arthritis [] Delay in Development [] High Cholesterol [] Sickle Cell Trait
[] Asthma [] Diabetes [] Kidney Problems [] Sickle Cell Disease
[] Autism [] Difficulty Walking [] Liver Disease [] Spina Bifida
[] Blood Disorders [] Dysplasia of Hip [] Neurological Disorder [] Thyroid Disease
[] Cancer : type _____ [] Gastrointestinal Disease [] Scoliosis [] Other*: _____
[] Cerebral Palsy [] Heart Disease

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: [] None
[] Abdominal Pain [] Convulsions [] Dizziness [] Painful Urination
[] Arthritis [] Decreased Appetite [] Dry Skin [] Recent Weight Change
[] Bleed Easily [] Depression [] Excessive Thirst [] Sleep Disturbances
[] Bruise Easily [] Difficulty Breathing [] Headaches [] Vomiting
[] Chronic Cough [] Difficulty Walking [] Loss of Hearing [] Worsening Vision


Has the patient had any of the following tests/procedures related to this problem? If yes, check and provide date.
[] X-ray ___/___ [] Physical Therapy ___/___ [] Pain Management ___/___
[] Myelogram ___/___ [] CAT Scan ___/___ [] MRI ___/___
[] Lab Work ___/___ [] Bone Scan ___/___ [] EMG/NCV ___/___

Pediatric Center Patient Worksheet


Date of Visit: _____ Patient Full Name: _____ OC # _____

Please mark an "X" to indicate the location of your child's 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

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