

PEDIATRIC ORTHOPAEDIC HISTORY

Child's Name: _____ Today's date: _____ MRN: _____

Age: _____ Date of Birth: _____ Height: _____, Weight: _____, Temp: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Symptoms/complaints & date of onset: _____

Is there a family history of this problem? _____

If this is an injury, how did it occur? _____

Have you seen any other doctor (including in an ER) for this? If yes whom, when, what treatment was given?

PATIENT'S MEDICAL HISTORY

Allergies: _____ Reaction: _____

Current Medications: _____ Include Dose _____ Route _____ How long? _____ Side Effects _____

Length of Mother's Pregnancy: _____ Type of Delivery: _____ Birth Weight: _____

Fetal Distress: No __, Yes __ Complications: _____

Surgeries/Hospitalizations _____ Year _____ Complications _____

When did patient first sit? _____ When did patient first stand? _____

For Female patients: Date of onset of first menstrual period: _____

FAMILY MEDICAL HISTORY

Health Status/Significant Medical Problems or Cause of Death of family members:

Patient's Mother's health: _____ & Father's health: _____

Patient's Sister/Brother's health: _____

Patient's Sister/Brother's health: _____

(OVER)

Reviewed by: _____ M. D. Date: _____

PEDIATRIC ORTHOPAEDIC HISTORY

Child's Name _____ DOB: _____ MRN # _____

SOCIAL HISTORY

Grade in school _____ N/A _____ Special Class _____ Early Intervention _____

Employed/Occupation _____ Language: English Spanish Other _____

Who lives at home with you? _____

Exercise/ Sports? No ___ Yes ___ Daily ___ Weekly ___ Monthly ___ Rarely ___

Type of exercise/ sports: _____

REVIEW OF SYSTEMS FOR THE PATIENT

Have you had any problems with your: (Circle yes or no. Describe yes responses below.)

Eyes: _____ N Y Heart/Cardiac: _____ N Y Muscle Weakness: _____ N Y

Ears, Nose, Throat: _____ N Y Lungs, Breathing: _____ N Y Neurological: _____ N Y

Digestion: _____ N Y Rash/skin Problems: _____ N Y Numbness/Tingling: _____ N Y

Bladder: _____ N Y Back Pain: _____ N Y Behavior/Psychological _____ N Y

Bowel function: _____ N Y Problems Walking: _____ N Y

Do you have other Medical Conditions: N ___ Y _____

Use of **assistive devices** or **orthotics**? Type and pattern of use: _____

Receives Physical Therapy? No Yes Frequency _____ Occupational Therapy? No Yes Frequency _____

Speech Therapy No Yes Frequency _____

Developmental data:

0 - 6 Months	N	Y	7 - 15 Months	N	Y	16 - 24 Months	N	Y
Head control			Sits Alone			Walks well		
Visually follows toys			Crawls			Uses utensils		
Reaches for objects			Pulls to standing			Climbs stairs		

Special concerns with development? _____

Parent/Guardian signature  _____

Date: _____

Reviewed by: _____ M. D. Date: _____