Pediatric Orthopedic Health History UPDATE

Matthew Wagner MD

Name of Patient: _____ **Today's Date**: ____/____/ 20____

Age: _____ **Date of Birth**: ____/____/____ Sex: ☐ Male ☐ Female

WHO IS FILLING OUT THIS FORM (AND RELATIONSHIP TO THE PATIENT): _____

PEDIATRICIAN (OR GROUP NAME): _____

REASON FOR TODAY'S VISIT: _____

ALLERGIES TO MEDICATIONS: ☐ None ☐ Yes…if so, what? _____

CURRENT MEDICATIONS: ☐ None ☐ Yes…if so, what? _____

PAST MEDICAL HISTORY: ☐ None ☐ Yes…if so, what? _____

PAST SURGICAL HISTORY: ☐ None ☐ Yes…if so, what? _____

REVIEW OF SYSTEMS: *(Please indicate if your child has a health problem in any of the following areas)*

No	Yes	System	Circle Condition(s), *if present* *or* Fill in for Other Conditions
☐	☐	Ears/Nose/Throat	(Deafness, Ear Infections, Sinusitis, Sore Throat) _____
☐	☐	Constitutional	(Fever or Chills, Recent Weight Loss) _____
☐	☐	Eyes	(Glasses/Contacts, Visual Disturbance) _____
☐	☐	Cardiovascular	(Exercise Intolerance, Murmur) _____
☐	☐	Respiratory	(Asthma, Shortness of Breath, Cough) _____
☐	☐	Gastrointestinal	(GERD, Abdominal Pain, Constipation, Nausea) _____
☐	☐	Genitourinary/Nephrology	(Incontinence, UTIs, Menstrual Irregularity) _____
☐	☐	Musculoskeletal	(Hypotonia, Fractures, Chronic Joint Pain) _____
☐	☐	Dermatologic	(Sacral Dimple, Rashes, Eczema, Unusual Birth Marks) _____
☐	☐	Neurologic	(Seizures, Headaches, Developmental Delay) _____
☐	☐	Psychiatric	(ADHD, Depression, Anxiety, Eating Disorder) _____
☐	☐	Endocrine	(Diabetes, Thyroid Disease, Obesity) _____
☐	☐	Hematologic/Lymphatic	(Anemia, Abnormal Bleeding, Sickle Cell, Enlarged Lymph Nodes) _____
☐	☐	Allergy/Immunology	(Hives, Lyme's Disease, Recurrent Infections, MRSA) _____

SOCIAL HISTORY:

What grade is your child in? _____

Involved in sports? ☐ No ☐ Yes…if so, please list: _____

Ht: _____ Wt: _____