

New Patient Pediatric Orthopedic Health History

Matthew R 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): _____

WHO REFERRED YOU OR HOW DID YOU HEAR ABOUT DR. WAGNER?: _____

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? _____

FAMILY MEDICAL HISTORY: MOTHER: _____ FATHER: _____ SIBLINGS: _____

BIRTH HISTORY: (For Children under age 10)

Born On Time? Yes No...if No, at how many weeks gestation was patient born? _____ weeks

What was the birth weight? _____

Did baby present in the Breech position? No Yes

Was patient born via C-Section? No Yes...if Yes, why? _____

Were there any complications with the pregnancy/delivery? No Yes...if Yes, why? _____

DEVELOPMENTAL HISTORY:

Age when first: Walked _____ Talked _____

Hand your child writes with? Right Left

[Girls: Age at first menstruation (i.e. periods)? _____ Not yet]

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
<input type="checkbox"/>	<input type="checkbox"/>	Ears/Nose/Throat	(Deafness, Ear Infections, Sinusitis, Sore Throat)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Constitutional	(Fever or Chills, Recent Weight Loss)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	(Glasses/Contacts, Visual Disturbance)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	(Exercise Intolerance, Murmur)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	(Asthma, Shortness of Breath, Cough)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	(GERD, Abdominal Pain, Constipation, Nausea)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary/Nephrology	(Incontinence, UTIs, Menstrual Irregularity)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	(Hypotonia, Fractures, Chronic Joint Pain)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Dermatologic	(Sacral Dimple, Rashes, Eczema, Unusual Birth Marks)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic	(Seizures, Headaches, Developmental Delay)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	(ADHD, Depression, Anxiety, Eating Disorder)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	(Diabetes, Thyroid Disease, Obesity)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic	(Anemia, Abnormal Bleeding, Sickle Cell, Enlarged Lymph Nodes)		_____
<input type="checkbox"/>	<input type="checkbox"/>	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: _____