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: _____

PEDIATRICIAN (OR GROUP NAME): _____

REASON FOR TODAY'S VISIT: _____

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

ANY ALLERGIES TO SHELLFISH, IODINE, OR LATEX? ☐ No ☐ Yes

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? _____Pounds _____Ounces

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
☐	☐	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: _____

Does the patient work? ☐ No ☐ Yes…if Yes, doing what? _____

Who does the patient live with? ☐ Parent(s) ☐ Other: _____

Special Diet? ☐ No ☐ Yes…if so, what dietary restrictions? _____

Tobacco use? ☐ No ☐ Yes…how much? _____

Alcohol Use: ☐ No ☐ Yes…how much? _____

Drug Use? ☐ No ☐ Yes…What? _____

This section to be completed by medical provider.

Ht: _____ Wt: _____

The medical history was reviewed by: _____ on _____/_____/ 20____.