WEST END ORTHOPAEDIC CLINIC

PEDIATRIC PATIENT HISTORY (Page 1 of 2)

Patient's Name: _____ Age: _____ Height: _____ Weight: _____

Social Security #:_____ Gender: ☐ M ☐ F Date of Birth: _____

Why is the patient seeing the doctor today? If an injury, please describe what happened and indicate the area where the patient is hurting:

_____

_____

Current problem is the result of a(n): *Check all that apply.*

☐ Car Accident ☐ Other accident/injury Location of accident/injury: ☐ Home ☐ Other- State: _____

Date of injury or onset of problem: _____

MEDICAL HISTORY *Is the patient currently receiving treatment or has the patient received treatment in the past for any of the following conditions?*

Y	N		Y	N		Y	N		Y	N	
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Low Blood Pressure	☐	☐	Sexually Trans-mitted Disease
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Lung Problems			
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Phlebitis/Blood Clots	☐	☐	Stroke
☐	☐	Birth Defects	☐	☐	Hepatitis	☐	☐	Polio	☐	☐	TB
☐	☐	Bladder Problems	☐	☐	HIV	☐	☐	Psychological	☐	☐	Thyroid Disease
☐	☐	Bleeding Disorder	☐	☐	High Blood Pressure	☐	☐	Recurrent Infection	☐	☐	Ulcer
☐	☐	Bowel Problems	☐	☐	Intestinal Disorder	☐	☐	Rheumatic Fever			
☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐	Scarlet Fever			

Please specify any other medical problems:

_____

ALLERGIES to DRUGS, LATEX, or ANESTHESIA *Please describe any current or past reactions.*

Patient is allergic to:	Reactions (itching, cough, hives, etc.):	How is/was reaction treated?

☐ Patient DOES NOT have any known allergies.

SURGICAL HISTORY & HISTORY OF HOSPITALIZATION

Type of surgery or reason for hospitalization	Date(s)	Treating physician	Hospital

☐ Patient DOES NOT have a history of surgery or hospitalization.

Has the patient ever had any problems with anesthesia? ☐ No ☐ Yes - describe: _____

PRIMARY CARE/PEDIATRICIAN Name: _____ Phone: _____

Address: _____

MOTHER Name: _____ Phone: _____
(Home) (Cell/Work)

FATHER Name: _____ Phone: _____
(Home) (Cell/Work)

Email address: _____
(mother) (father)

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PEDIATRIC PATIENT HISTORY (Page 2 of 2)

Patient's Name: _____

FAMILY HISTORY *Have the patient's mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?*

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Tuberculosis ☐ Kidney Disease ☐ Arthritis ☐ None of these

☐ Other (specify):_____

PLEASE LIST HEALTH STATUS OR CAUSE OF DEATH FOR THE FOLLOWING FAMILY MEMBERS:

Mother: _____ Father: _____

Siblings: _____

BIRTH/DEVELOPMENTAL HISTORY *(for children 17 years of age or younger)*

Pregnancy concerns or complications: _____

Labor and delivery concerns or complications: _____

Birth Weight: _____ How many days in the hospital after delivery? _____

Age patient accomplished: Sit _____ Crawl _____ Stand _____ Walk _____ Speak 3 words _____

Preschool attendance: ☐ Yes ☐ No Current school grade or N/A: _____

REVIEW OF SYSTEMS *Please mark which symptoms the patient has experienced on a regular basis.*

GENERAL
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

EYES
- ☐ Blurring
- ☐ Eye strain
- ☐ Glasses/contacts
- ☐ Discharge

THROAT
- ☐ Soreness
- ☐ Hoarseness
- ☐ Difficulty swallowing

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation

SKIN
- ☐ Eruptions/rashes
- ☐ Cyanosis (bluish tint)
- ☐ Jaundice (yellow tint)

EARS
- ☐ Deafness
- ☐ Ringing in ears
- ☐ Pain
- ☐ Discharge

GENITOURINARY
- ☐ Pain
- ☐ Frequent urination
- ☐ Incontinence

NEUROMUSCULAR
- ☐ Weakness
- ☐ Joint pain
- ☐ Tingling
- ☐ Varicosity
- ☐ Deformities

HEAD
- ☐ Headache
- ☐ Fainting/blackouts
- ☐ Trauma

NOSE
- ☐ Sinusitis
- ☐ Obstruction

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Rapid/throbbing heartbeat
- ☐ Faintness
- ☐ Fluid/swelling in extremities

RESPIRATORY
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Bloody sputum

Date of last chest x-ray: _____

MEDICATIONS

Is the patient **CURRENTLY** taking any medications **prescribed by a physician**? ☐ Yes ☐ No

If yes, please list medication, dosage, prescribing physician, and how long patient has been taking the medication:

_____

Is the patient **CURRENTLY** taking any **over the counter** medications? ☐ Yes ☐ No

If yes, please list: _____

Reviewed by: _____, **M.D.** **Date:** _____