



PEDIATRIC ORTHOPAEDIC HISTORY

Name _____ Date _____

SS#: _____ Date of birth: _____

CHIEF COMPLAINT: Why is your child seeing the doctor today? _____

Current problem is the result of: (check all that apply)

Car accident Other accident Other Date of accident: _____

Referring doctor name _____ Phone _____

Address _____

Medication	Dosage	Reason for medication	Any side effects?

Does your child have allergies? Yes No If yes, please list:

Are immunizations up to date? Yes No If no, which immunizations are due?

REVIEW OF SYSTEMS

Has your child ever had problems with any of these items? Please describe all YES responses.

	NO	YES	DESCRIPTION
Eyes			
Ears, nose, throat			
Lungs, breathing			
Digestion			
Bowel movement			
Bladder problem			
Diabetes			
High blood pressure			
Bleeding problem			
Balance problem			
Numbness/tingling			
Blackout/fainting			
Psychological problem			
AIDS			
Cancer			
Arthritis			
Polio			
TB			
Epilepsy			

Please list all past surgeries and hospitalizations:

REASON	YEAR	COMPLICATIONS?

Has your child ever had general anesthesia? yes no

Have any problems with anesthesia? yes no (if yes, please describe)

Pregnancy and Birth:

Pregnancy was normal complicated

Pregnancy complications _____

Birth was on time premature late vaginal caesarean induced

Birth complications _____

Family history:

	ALIVE	DECEASED	AGE	HEALTH STATUS OR CAUSE OF DEATH
Child's mother				
Child's father				
Grandmother (maternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandfather (paternal)				
Sister or brother				
Sister or brother				
Sister or brother				
Sister or brother				

Social History: Day Care Pre-school Student (Grade ____)

Sports _____

Activities _____

Thank you for your time in completing this information!

Parent signature: _____ Date _____

Reviewed by: _____, M.D. Date _____