PATIENT HISTORY FORM Children's Orthopedic Center

Patient's Name_____ Age: _____ Today's Date: _____
Patient's Date of Birth _____ Height _____ Weight _____

Reason for Visit (If injury, please describe what happened, and the location of any pain)
_____

When did you first notice the problem? _____
Result of an accident? Yes No If yes, where and when? _____
Prior Treatment? Yes No If yes, where and by whom? _____
X-Rays Taken: Yes No If yes, Date Taken: _____ Where: _____

Past Medical History –
Does the patient have any major medical problems? If so, describe:

Is the patient under treatment, or has ever been treated for any of the problems listed below?

	Yes	No		Yes	No
Anemia	___	___	Currently Pregnant	___	___
Asthma	___	___	Stomach Problems	___	___
Arthritis	___	___	Urine Problem	___	___
Birth Defects	___	___	Bleeding Disease	___	___
Epilepsy	___	___	Recurrent Infections	___	___
Heart problems	___	___	Intestinal Disorders	___	___
Breathing Problems	___	___	Kidney Problem	___	___
Psychological	___	___	Endocrine Problem	___	___
Previous Fracture	___	___	Other (if significant)	___	___

Has the patient ever been **hospitalized**? No____ (If yes, please describe if not mentioned above)
_____
Are **immunizations** up to date? Yes _____ No _____
Any drug **Allergies**? No? _____ (If so, please list medications and type of reaction)
_____
Is the patient currently taking any **medications**? No _____ (If so, list name, dose and frequency)
_____
_____
Has the patient had any **surgery** in the past? No _____ (If so, please describe)
_____
Any concerns regarding **growth or development**? No _____ (If so, please describe)
_____
Were there any significant problems related to patient's **birth**? No _____ (If so, please describe)
_____
Are there any other health or general concerns that may be relevant? (Please note any participation in highly competitive sports)_____
_____

Name of primary physician_____ Phone# _____
Office where patient is usually seen, if applicable _____

FAMILY HISTORY

If not being seen for an injury, have any close relatives had problems similar to the patient's problem?
No ____ If yes, please describe:_____
_____

Any major medical problems run in the family?

Any close family members with:	Yes	No	Other possibly relevant?
Scoliosis	___	___	
Birth Defects	___	___	
Asthma or breathing problems	___	___	
Heart Disease	___	___	
Endocrine problems (Diabetes, thyroid)	___	___	
Reaction to anesthesia	___	___	
Bleeding or hematologic problems	___	___	
Seizures or Epilepsy	___	___	

Family history not known _____

SOCIAL HISTORY

With whom does the patient live? _____
Any recent major events? _____
Any special school requirements or athletic interests? _____
If patient is not a student, patient's occupation or other activity? _____

REVIEW OF SYSTEMS – Please mark any symptoms the patient has experienced recently or has experienced on a regular basis

General
___ fever
___ weight loss
___ other

Skin
___ rash
___ unusual bite wound
___ other

Head
___ headache
___ fainting, blackouts
___ other

Eyes
___ discharge, red
___ glasses, contact lens
___ other

Ears
___ frequent infections
___ ringing in ears
___ other

Genitourinary
___ pain
___ frequency
___ unexpected incontinence
___ other

Cardiovascular
___ heart murmur
___ chest pain
___ rapid heartbeat
___ other

Psychological
___ depression
___ other

Gastrointestinal
___ nausea
___ constipation
___ diarrhea
___ reflux
___ other

Neuromuscular
___ weakness
___ tingling
___ deformities
___ behavioral
___ development
___ other

Respiratory
___ shortwinded
___ asthma
___ cough
___ other

Nose and Throat
___ sinusitis
___ drainage
___ other

Hematologic/ Immunologic:
___ excess bleeding or prone to infection
___ other

Signature of person filling out form _____
Reviewed by MD _____