Label

ORTHOPAEDIC PATIENT HISTORY

Patient Name: _____ **Date of birth:** _____
Person completing form: _____ **Relation:** _____

Primary Care Provider: _____ **Preferred pharmacy & location:** _____

REASON FOR VISIT: _____

SOCIAL HISTORY: Grade in school: _____ School: _____ # of Siblings _____

With whom does patient live? _____ Parents' Occupation _____

BIRTH HISTORY: Birth weight: _____ lb _____ oz Gestation Age: How many weeks? _____ Full term ☐ Premature ☐
Delivery: Vaginal ☐ C-section ☐ Complications? No ☐ Yes ☐ _____
Medical problems for baby after delivery? No ☐ Yes ☐ _____

IMMUNIZATIONS: Is patient up to date? No ☐ Yes ☐

SURGERIES: No ☐ Yes ☐ If yes, list the type and date _____

HOSPITALIZATIONS: No ☐ Yes ☐ If yes, list the type and date _____

MEDICATIONS/SUPPLEMENTS: No ☐ Yes ☐ If yes, list the name and dose _____

_____

Medication Allergies: No ☐ Yes ☐ If yes, list the name & reaction _____

Family History: Scoliosis No ☐ Yes ☐ Clubfoot No ☐ Yes ☐ Other Family History _____
Hip Dysplasia No ☐ Yes ☐ Inflammatory Arthritis No ☐ Yes ☐ _____

REVIEW OF SYSTEMS: Does your child have any of the following now or in the past?

	No	Yes
Constitutional		
Unusual weight loss	☐	☐
Repeated unexplained fevers	☐	☐
Allergies		
Seasonal allergies	☐	☐
Food allergies	☐	☐
If yes, please list _____		
Blood/Circulation		
Anemia	☐	☐
Bleeding tendencies	☐	☐
Sickle cell trait/disease	☐	☐
Cardiovascular		
Heart Problems	☐	☐
If yes, explain _____		
Dermatology		
Skin rashes	☐	☐
If yes, explain _____		

	No	Yes
Endocrine		
Thyroid problems	☐	☐
Diabetes	☐	☐
Growth problems	☐	☐
Menstrual periods	☐	☐
LMP _____ 1st MP _____		
Ears, Nose & Throat		
Recurrent ear/sinus infections	☐	☐
Snoring	☐	☐
Eye		
Vision problems	☐	☐
GI		
Jaundice	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Vomiting	☐	☐
Stomach pain	☐	☐
Kidney/urinary problems		
Urine infections	☐	☐
Musculoskeletal		
Joint problems	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Scoliosis	☐	☐
Broken bones	☐	☐

	No	Yes
Respiratory		
Pneumonia	☐	☐
Asthma/Reactive airway	☐	☐
Persistent cough	☐	☐
Neuro/Developmental		
Learning disorders	☐	☐
ADHD	☐	☐
Genetic problems	☐	☐

Other _____

_____

Signature:

_____

Date:

_____