Medical Orthopedic History Form for Children

Name: _____ DOB: _____ Today's Date _____

Birth History for Patient:

Was the pregnancy full term? (Y or N)

Complications of pregnancy or delivery? _____

Have any congenital abnormalities found then or since? _____

Onset of Illness or Injury

Was there an accident? (Y or N) If so how? _____ Where? _____

Was the problem gradual in onset? When did symptoms first appear? _____

Past Medical History: Has the child had any of the following Conditions?

- ☐ Abdominal problems?
- ☐ Any serious injury?
- ☐ Behavior problems?
- ☐ Broken bones previously?
- ☐ Chronic Cough?
- ☐ Frequent Temper Tantrums?
- ☐ Hay fever/Sinus problems?
- ☐ Joint swellings or pain?
- ☐ Kidney or bladder infections?
- ☐ Many ear infections?
- ☐ Over weight?
- ☐ Pneumonia?
- ☐ School problems
- ☐ Seasonal Allergies
- ☐ Seizures?
- ☐ Skills behind other kids?
- ☐ Underweight?
- ☐ Vision Problems?
- ☐ Other? _____

Any allergies to Medications? _____

Any Medications/supplements taken frequently? _____

Social History:

Child has how many sisters? _____ Brothers? _____

Usual Grades received? _____(A,B,C's Etc.)

Participate in sports? Y or N: Kind of sport? _____

Who lives in your home? _____

Family History: Has any blood relative of your child had:

- ☐ Alcoholism?
- ☐ Allergies?
- ☐ Bleeding disorder?
- ☐ Blood clots?
- ☐ Cancer?
- ☐ Deafness?
- ☐ Depression?
- ☐ Diabetes?
- ☐ Drug Addiction?
- ☐ Heart Problems?
- ☐ Heart vessel surgery?
- ☐ High blood pressure?
- ☐ High Cholesterol?
- ☐ Lung disease or COPD?
- ☐ Mental illness?
- ☐ Attention deficit disorder or hyperactivity?
- ☐ Seizures?
- ☐ Strokes?
- ☐ Tuberculosis (TB)?
- ☐ Other conditions? _____

Parent's or Guardian's Signature: _____