PATIENT HEALTH HISTORY

Please complete the following questions accurately. The information you provide will help us plan the best possible care for your child. If you are unsure how to answer questions, please ask for help.

Form Completed by: _____ Date _____

Relationship: _____ Chief Complaint/Orthopedic Concern: _____

Has the patient been evaluated or treated for this condition by another physician? If yes, please provide physician's name, address, and description of treatment. _____

_____

Medications (include non-prescription and vitamins): _____

PAST HEALTH HISTORY

Has the patient ever had any of the following?		Describe all **YES** responses
Problems during pregnancy / delivery with this child	☐Yes ☐No	_____
Hospitalization(s) (included reason and date)	☐Yes ☐No	_____
Surgeries (include procedure and date)	☐Yes ☐No	_____
Complication with surgery / anesthesia	☐Yes ☐No	_____
Allergies or drug sensitivity	☐Yes ☐No	_____
History of orthopedic concerns or fractures	☐Yes ☐No	_____

DEVELOPMENT AND ACTIVITIES

Can the patient (please check): ☐Sit _____ ☐Crawl _____ ☐Stand _____ ☐Walk _____
(Answer only if patient is 5 or younger) *Age* *Age* *Age* *Age*

Does the patient keep up with other kids his/her age? ☐Yes ☐No

What grade is the child in?_____

Does he/she receive any of the following therapies?

Physical therapy ☐Yes ☐No Therapist & Clinic _____

Occupational therapy ☐Yes ☐No Therapist & Clinic _____

Speech & Hearing ☐Yes ☐No Therapist & Clinic _____

Is the patient currently under the care of any other physician(s)? Please list all: _____

_____

Does the child have a ☐**HIGH** ☐**NORMAL** ☐**LOW** pain threshold?

Is it necessary for you to cut the tags out of your child's clothing? ☐Yes ☐No

REVIEW OF SYSTEMS

Does the patient currently have or had any of the following? Describe all **YES** responses

Ear, throat, or sinus infections	☐ Yes ☐ No	
Vision or hearing problems	☐ Yes ☐ No	
Swallowing or eating problems	☐ Yes ☐ No	
Headaches	☐ Yes ☐ No	
Respiratory or lung problems	☐ Yes ☐ No	
Heart problem or heart murmur	☐ Yes ☐ No	
Excessive bleeding or bruising	☐ Yes ☐ No	
Stomach or bowel problems	☐ Yes ☐ No	
Kidney or bladder problems	☐ Yes ☐ No	
Muscle or bone problems	☐ Yes ☐ No	
Diabetes or thyroid problems	☐ Yes ☐ No	
Problems with growth or weight	☐ Yes ☐ No	
Skin problems	☐ Yes ☐ No	
Numbness or tingling	☐ Yes ☐ No	
Seizures, paralysis, or spasticity	☐ Yes ☐ No	
Learning, behavioral, ADHD problems	☐ Yes ☐ No	
Depression, Anxiety problems	☐ Yes ☐ No	

FAMILY HEALTH HISTORY

Do family members (parents, grandparents, siblings) have any of the following? Describe all **YES** responses

Bleeding problems	☐ Yes ☐ No	
Lung problems	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
Heart disease	☐ Yes ☐ No	
Kidney disease	☐ Yes ☐ No	
Muscle or bone problems (Arthritis, scoliosis, and joint problems)	☐ Yes ☐ No	
Cancer (include type)	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Diseases that “run in the family” (Please specify)	☐ Yes ☐ No	
Anesthesia problems (Malignant hyperthermia)	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Osteoporosis	☐ Yes ☐ No	
Fibromyalgia	☐ Yes ☐ No	

Are there other children in the family? Ages: _____ Health: _____

Any comments or information you would like us to know? _____

clear form

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