Washington University in St. Louis
SCHOOL OF MEDICINE

PEDIATRIC HEALTH HISTORY

PLEASE USE BLUE OR BLACK INK ONLY

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Height:_____ ft _____ in Weight:_____ lbs

Your Child's Primary Doctor Name and Address:

_____

_____

Preferred Pharmacy (Address/Phone):

_____

_____

PAST MEDICAL HISTORY: ***Check all that apply*** ☐ ***None Apply***

- ☐ Downs syndrome
- ☐ Muscular Dystrophy
- ☐ Neurofibromatosis
- ☐ Seizures
- ☐ Cerebral palsy
- ☐ Spina bifida or Myelodysplasia
- ☐ Genetic syndrome or chromosome disorder_____
- ☐ Asthma
- ☐ ADHD
- ☐ Rheumatoid arthritis
- ☐ Thyroid problems
- ☐ Hepatitis (A, B or C)
- ☐ HIV/AIDS
- ☐ Heart murmur
- ☐ Abnormal heartbeat
- ☐ Bleeding disorder
- ☐ Rickets
- ☐ Lead poisoning
- ☐ Kidney problems
- ☐ Diabetes Mellitus

☐ Other: _____

_____

Birth History:

☐ Premature ☐ Full term ☐ C-Section ☐ Vaginal Delivery ☐ Breech

Birth weight: _____ lbs. ____ oz.

Please explain any birth complications:_____

_____

Developmental History: ☐ ***Check here if the patient/your child has had no developmental delays***

Did your child have any delays in the following:

Rolling over	☐ No	☐ Yes, explain_____
Sitting independently	☐ No	☐ Yes, explain_____
Standing independently	☐ No	☐ Yes, explain_____
Walking holding onto furniture	☐ No	☐ Yes, explain_____
Walking independently	☐ No	☐ Yes, explain_____

Are all immunizations up to date? ☐ No ☐ Yes

Menstrual History:

Age at first menstrual period_____

Date of last menstrual period_____

Is there any chance the patient could be pregnant? ☐ No ☐ Yes ***(***Please let us know before X-Rays are taken***)***

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Name:_____ Date of Birth:_____

PAST SURGICAL HISTORY: ☐ ***No prior surgery***

Operation	Date	Surgeon/Hospital

Has your child ever had general anesthesia? ☐ No ☐ Yes
If YES, any problems related to this? ☐ No ☐ Yes
Please explain any problems related to general anesthesia: _____

_____

_____

_____

MEDICATIONS (prescribed and over the counter): ☐ ***I take no medications***

Name of Medication	Dose	Reason

ALLERGIES TO MEDICATIONS: ☐ ***None***

Name of Medication	Reaction (rash, swelling, stomach upset, etc.)

SOCIAL HISTORY:

Grade level in school: _____ School attended:_____

Patient's parents are ☐ Married ☐ Divorced ☐ Separated ☐ Not Married

Patient lives with:_____

Sports Played: _____

Number of Brothers/Sisters_____ Is there smoking in the house?_____

Does the patient smoke?_____ If yes, how many packs a day?_____

Alcohol Use ☐ Yes ☐ No
Illegal Drug Use ☐ Yes ☐ No

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Name:_____ Date of Birth:_____

FAMILY HISTORY: Check all that apply ☐ None apply

	Father	Mother	Brother	Sister	Son	Daughter	Other (Grandparent, etc.) (Specify)_____
Diabetes							
Bowlegs							
Roundback/Kyphosis							
Scoliosis							
Spondylolisthesis							
Arthritis							
Hip Problems							
Low Back Pain							
Bleeding Problems							
Perthes Disease							
Other: _____							

REVIEW OF SYSTEMS (check all that apply within the last 30 days):

☐ Fever
☐ Chills
☐ Weight loss
☐ Weight gain
☐ Glasses/contacts
☐ Vision changes
☐ Hearing loss
☐ Ear pain
☐ Sleep apnea (snoring)
☐ Cough
☐ Trouble swallowing
☐ Seizures
☐ Palpitations
☐ Seasonal allergies
☐ Food allergies
☐ ADHD
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Skin rashes
☐ Gastric Reflux
☐ Urinary tract infections
☐ Other:_____

☐ ***None of the above symptoms have occurred in the last 30 days***

PLEASE NOTIFY THE PHYSICIAN AND THE RADIOLOGY TECHNICIAN PRIOR TO OBTAINING ANY RADIOGRAPHS IF THERE IS ANY CHANCE THE PATIENT COULD BE PREGNANT.

This information is collected because it may impact your child's orthopaedic care. Your primary care physician should be aware of this information.

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient/family:

Physician Signature:_____ Date:_____