Washington University in St. Louis
SCHOOL OF MEDICINE

PEDIATRIC ORTHOPEDIC HISTORY

PLEASE USE BLUE OR BLACK INK ONLY

Name of Patient:_____ Date:_____

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

Your Child's Primary Doctor Name and Address:

_____

_____

Referring Doctor Name and Address:

_____

_____

What problem is the doctor seeing your child for today?_____

On which side is the problem? ☐ Right ☐ Left ☐ Both ☐ Back/Spine

How long has the pain/problem been present?_____

Has the pain/problem worsened recently? ☐ No ☐ Yes, how recently?_____

Did your child have an injury and if so what caused the injury?_____

Quality of the pain ☐ Sharp ☐ Burning ☐ Dull ☐ Aching

How severe is the pain at the location described above?

☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

What makes the pain/problem better?_____

What makes the pain/problem worse?_____

Is the pain (check all that apply): ☐ Continuous ☐ Activity related ☐ Night pain ☐ Unpredictable

What other treatments have you tried?

☐ Physical Therapy/Exercise	☐ TENS unit	☐ Narcotic medications	☐ Cast/boot
☐ Massage/Ultrasound	☐ Traction	☐ Anti-Inflammatories	☐ Orthotics
☐ Chiropractic treatment	☐ Surgery	☐ Steroid injections	☐ Braces

Previous physicians seen for ***this*** problem

Physician	Specialty	City	Treatment

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Name of Patient:_____ Date of Birth:_____

Medications taken for ***this*** problem

Name of Medication	Dose	Reason

X-Rays and Tests for ***this*** Problem:

	Results	Date	Location
☐ X-Rays			
☐ MRI			
☐ CT Scan			
☐ Bone Scan			
☐ Ultrasound			
☐ Other			

Because of this problem, have you filed or do you plan to file a lawsuit? ☐ Yes ☐ No

If your child is a new patient to our practice, please complete the ***Pediatric Health History***. If you have previously completed a ***Pediatric Health History*** during a visit to our practice, have there been any changes to your child's medical history, surgical history or medications since that time? Please describe any changes below:

_____

_____

_____

FOR OFFICE USE ONLY

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

Provider Signature:_____ Date: _____

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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):

_____

_____

ALLERGIES (i.e. medications, foods, other) ☐ ***No Allergies***

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

MEDICATIONS (prescribed and over the counter, to include contraceptive meds): ☐ ***No medications***

Name of Medication	Dose	Reason

Are all immunizations up to date? ☐ No ☐ Yes

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

☐ Anemia
☐ Autism: _____
☐ Autoimmune disorder: _____
☐ Arthrogryposis
☐ Attention-deficit/hyperactivity (ADD/ADHD)
☐ Asthma
☐ Bleeding disorder
☐ Blood clotting disorder
☐ Cancer, type/treatment: _____
☐ Cerebral palsy
☐ Diabetes mellitus
☐ Down syndrome
☐ Eczema
☐ Ehlers- Danlos
☐ Genetic syndrome/chromosome disorder: _____
☐ Heart murmur
☐ Heart valve problem
☐ Hepatitis (A, B, or C)
☐ Inflammatory bowel disease
☐ HIV/AIDS
☐ Kidney disease
☐ Lead poisoning
☐ MRSA infection/colonization
☐ Osteomyelitis/ bone infection
☐ Nerve / muscle disease
☐ Neurofibromatosis
☐ Previous anesthesia complication: _____
☐ Rheumatoid arthritis
☐ Rickets
☐ Seasonal allergies (allergic rhinitis)
☐ Scoliosis (spine/back curvature)
☐ Seizures
☐ Sickle cell anemia/trait
☐ Spina bifida
☐ Other: _____

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PEDIATRIC HEALTH HISTORY

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: _____

_____

_____

FAMILY HISTORY: Check all that apply ☐ ***None apply***

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

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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PEDIATRIC HEALTH HISTORY

Name:_____ Date of Birth:_____

BIRTH HISTORY

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

Birth weight: _____ lbs. ____ oz.

Please explain any birth complications:_____

_____

DEVELOPMENTAL HISTORY ☐ ***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_____

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 <u>before</u> X-Rays are taken***)***

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.

*****Please continue on page four*****

Name:_____ Date of Birth:_____

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

- ☐ Arm numbness
- ☐ Arm weakness
- ☐ Bronchitis
- ☐ Chills
- ☐ Constipation
- ☐ Cough
- ☐ Diarrhea
- ☐ Difficulty controlling bowel/bladder
- ☐ Ear pain
- ☐ Fever
- ☐ Food allergies
- ☐ Gastric reflux
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heavy menses
- ☐ Leg numbness
- ☐ Leg weakness
- ☐ Nausea
- ☐ Palpitations
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Skin rashes
- ☐ Sleep apnea (snoring)
- ☐ Trouble swallowing
- ☐ Urinary tract infection
- ☐ Vision changes
- ☐ Vomiting
- ☐ Weight gain
- ☐ Weight loss

☐ Other:_____

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

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

Provider Signature:_____ Date: _____