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

 Revised 8/2011

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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:

Physician Signature: ______________________________ Date: ______________