PEDIATRIC PATIENT HISTORY

Patient Name: ________________________ Date of Birth: __________________ Age: _________

Problem or Complaint: ____

Duration: _______________ Previous treatment or x-rays:________________________________

Past History: List all surgeries and hospitalizations: _____________________________________

Name of Pediatrician: ________________________

Current Medications: ____

Allergies: ____

Developmental History: ____

Birth Order: ___________________________ Number of Siblings: ___________________________

Full term pregnancy: Yes __________ No ___________ Delivery: Vaginal _____ C-Section _______

Any complications for mom or child during pregnancy or birth? ______________________________

Family History: Please list foot, ankle, leg, knee and hip problems in the patients immediate family, listing member's relation and current age:

Mother ________________________________ Father ______________________________________

Brothers _______________________________ Sisters _____________________________________

Other Family: ____

System Review: Please check the appropriate spaces if the patient has a problem history in the corresponding area: Elaborate below:

Head______ Heart ______ Abdominal Pain ______ Burning or pain on urination ______ Eye ______

Lungs ______ Nausea ______ Bone or Joint Pain ______ Ear ______ Asthma ______

Abnormal or bloody stools ______ Diabetes ______ Nose ______ Bronchitis ______

Kidney Disease ______ Cancer ______ Throat ______ Stomach Ulcer ______ Liver Disease ________

Other ____