

Chart: _____ Age: _____ **Child Medical History Form** Prov: _____
 Name _____ Date _____

Referring Physician _____ Pediatrician (If Diff) _____
 Grade in School _____ Legal Guardian _____

Who does the child live with? _____
 Reason for Consulting an Orthopaedic Surgeon _____
 Describe Side and Location (for example, right knee) _____
 What are the symptoms? _____
 How long have the symptoms been present _____
 Is this a result of an injury? Yes No Date ____/____/____
 If yes, how did it happen? _____
 If Yes, where did it happen? _____
 Have you had any tests, treatments, or xrays for this condition? _____
 Past serious injuries or accidents _____

Pregnancy Problems? _____
 Delivery Problems? _____
 Development Problems? _____

Major Operations or Illnesses or Fractures

| Hospital | Date | Reason |
|----------|------|--------|
| | | |
| | | |

Conditions that run in your family (arthritis, diabetes, heart disease) _____

Does the child have or ever have

- | | | | |
|----------------------|-----------------------|------------------------|------------------|
| Abnormal Bleeding | Diabetes | Kidney Disease | Recent Cold/Flu |
| AIDS (HIV) | Fever, Chills, Sweats | Liver Disease | Rheumatic Fever |
| Anemia | Glaucoma | Lung Disease | Sinus Problems |
| Arthritis | Headaches-Frequent | Marked Weight Loss | Stomach Troubles |
| Asthma | Heart Trouble | Nervous Disorder | Stroke |
| Blood Clots | Herpes | Pain in Jaw | Swollen Glands |
| Chemotherapy | High Blood Pressure | Radiation Treatment | Thyroid Disease |
| Convulsions/Epilepsy | Jaundice | Reaction to Anesthetic | Veneral Disease |

Other: _____

Medications (Can use back of page)

| Medication | Dosage | Reason |
|------------|--------|--------|
| | | |
| | | |

List any allergies (and what is the reaction) _____

Smoking? Y N If yes, how much _____

Drug or Alcohol Use? _____

Emotional Problems? _____

Height _____ Weight _____
 Female Only: Menses: Age Began _____ Regular? _____

| | |
|-------------|--------|
| Office Use: | Chart: |
| Last Name: | |
| First Name: | |
| Age: | DOB: |