

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

<u>Hospital</u>	<u>Date</u>	<u>Reason</u>

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)

<u>Medication</u>	<u>Dosage</u>	<u>Reason</u>

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: