Date: ________________
Account #:____________
Physician:____________

Midwest Orthopaedic Institute, P.C.

Pediatric Patient History Sheet

Patient Name:____ Date of Birth:__________ Age:___Y___ M

Reason for today's visit: _____________________________________ Male / Female Height:______ Weight:______

Date of injury/Onset of pain (*required*)__________________________ Is your pain/injury a result of an accident? Y / N

How did the accident occur? ____

Primary Physician: _____________________________ Referring Doctor/Source:______________________________

Developmental History:

Are you: Right Handed _____ Left Handed_____ Shoe size: Child _____ Adult______

Born at: ______weeks gestation Vaginal delivery _____ C-Section______

Left hospital with mom: Yes / No Admitted to the hospital: Yes / No If so #: ______ days

In-Utero drug/alcohol exposure: Yes / No

Adopted: Yes / No Age: _________ From where: ____________________________

Age at which patient first: Sat: __________ Crawled: __________ Walked: _____________

Age at first Menstruation: __________ Date of most recent period: ____________

Review of Systems: Check if you have problems currently or have had in past

	YES	NO	If yes, please explain:
Eyes/Ears/Nose/Throat:..	( )	( )	______________________________
Respiratory Problem (Asthma, Lung Disease):..............................	( )	( )	______________________________
Heart Disease:..	( )	( )	______________________________
Genetic Disorder:...	( )	( )	______________________________
Blood/Bleeding Disorders/Anemia:..	( )	( )	______________________________
Congenital Deformity:...	( )	( )	______________________________
Diabetes:...	( )	( )	______________________________
Neurological Problems (Seizures, CP, Spina Bifida):.......................	( )	( )	______________________________
Stomach Ulcers or other Gastrointestinal Problems:........................	( )	( )	______________________________
Cancer (What kind?) (Lymphoma?):..	( )	( )	______________________________
Hepatitis:..	( )	( )	______________________________
Tuberculosis:...	( )	( )	______________________________
Polio:..	( )	( )	______________________________
Skin problems:..	( )	( )	______________________________
Musculoskeletal Problems: (Arthritis, Scoliosis, Dysplasia):..............	( )	( )	______________________________
Kidney/Bladder Disease:...	( )	( )	______________________________
Thyroid Problems (hyper/hypo):..	( )	( )	______________________________
Attention Disorder / Autism / Psychiatric History:........................	( )	( )	______________________________
HIV Disease:..	( )	( )	______________________________
Any other medical condition:..	( )	( )	______________________________

PLEASE COMPLETE OTHER SIDE

Past Social History:

Marital Status of parents: S M W D Do you live with: _____ mom______ dad _____ both

Activities or sports you're involved in: ____

Tobacco Use: Yes / No Amount: ___________ Age at first use: _________ Quit smoking? Yes / No

Past Surgical History: Please List **all** surgeries and dates that you have had

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Past Hospital Admissions: Please List **all** Admissions and dates you have had

______________________________________ ______________________________________

______________________________________ ______________________________________

Do you have Allergies to Food or Drugs? Y N
Please describe:

Medications: ☐ **See attached list** **Pharmacy: _____________________ (city)____________**

Please list **ALL** prescription, over-the-counter, and herbal medications you may be taking. Also, please list the dosage, frequency, and reason for each medication.

Name of Medication	*Dosage*	*Frequency*	*Reason*

Past Family History:

		Age:		Musculoskeletal History or Major Medical History or Cause of Death:
Mother:	Alive/Deceased	____	Height: ____ft.____inches	______________________
Father:	Alive/Deceased	____	Height: ____ft.____inches	______________________
Siblings:	Alive/Deceased	____		______________________
	Alive/Deceased	____		______________________
	Alive/Deceased	____		
	Alive/Deceased	____		

Patient/Parent Signature: ______________________________________ Date: ________________

Ortho Tech Signature: ______________________ Doctor Initials: ______________ Date:________________