

Cape Fear Orthopaedic - PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

FOR OFFICE USE ONLY

X-rays	Y N	Date of Injury/Onset _____	Seen by provider # _____
MRI	Y N	Interviewers Initials _____	Date Interviewed _____
CT scan	Y N		
Medical Records	Y N		
Other Test	Y N		

Chart # _____ Patient (Legal) Name _____
 Date of birth _____ Gender: Male Female Age _____ (Last) (First) (Middle) Height _____ Weight _____
 Referring Physician _____ Primary Care Physician _____
 Reason for today's visit _____ When did the injury/problem occur? _____

HEALTH HISTORY OF PATIENT

Immunizations up-to-date----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Delay in development----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty walking----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental illness----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Serious injuries----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorders----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/bladder trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disease----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Other illness----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

Explain all "yes" answers: _____

List ALL operations and approximate date: _____ Current medications and dosage: _____ List ALLERGIES to medications----- NONE

FAMILY HISTORY

Heart problems----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental illness----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/Bladder trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorders----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Other----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

Explain all "yes" answers: _____

SOCIAL HISTORY

Number of people living in child's home _____ Grade in school _____
 How many are adults (number and relationship) _____ Smoke _____ packs per day
 How many are brothers (number and ages) _____ Alcohol use----- None Occasional
 How many are sisters (number and ages) _____ Illicit Drug use----- None Presently Past
 Other's (number and ages) _____

DEVELOPMENTAL HISTORY (if child is younger than 2 years of age)

Roll over back to front----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Sit with support----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Crawl----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Pull to a stand----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Walk independently----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Run----- <input type="checkbox"/> Yes <input type="checkbox"/> No

DEVELOPMENTAL HISTORY (if child is 2 to 6 years of age)

Stairs, one leg at a time----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Stairs, alternating legs----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Jumps----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Hops on one foot----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Skips----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

REVIEW OF SYSTEMS (Present NOW or Past 2 months)

Chills or fever----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Unusual weight change----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent headaches----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Exhaustion----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Change in vision----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Reading glasses----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of hearing----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent nosebleeds----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty swallowing----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart or chest pain----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Poor appetite----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Toothache/gum trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea or vomiting----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach pain----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent constipation----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent loose bowel movements <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination (passing water) <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation during urination-- <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent rash----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Hot or cold spells----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

Form Completed by _____ Relationship _____ Date _____

Reviewed by _____ MD/PA-C Date _____