Cape Fear Orthopaedic Clinic, P.A.: Pediatric Medical History Questionnaire *(Effective 1/1/2007)*

FOR OFFICE USE ONLY

X-rays Y N
MRI Y N
CT scan Y N
Medical Records Y N
Other Test Y N

Date of Injury/Onset____________________________ Seen by provider #_______________________

Interviewers Initials____________________________ Date Interviewed________________________

Chart #________________________ Patient (Legal) Name____
(Last) *(First)* *(Middle)*

Date of birth___________________ Gender: □ Male □ Female Age_______ 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----------□ Yes □ No
Seizures-------------------------------□ Yes □ No
Arthritis-------------------------------□ Yes □ No
Anemia--------------------------------□ Yes □ No
Asthma--------------------------------□ Yes □ No
Thyroid disease----------------------□ Yes □ No
Delay in development------------- □ Yes □ No
Mental illness---------------------- □ Yes □ No
Cancer------------------------------- □ Yes □ No
Heart trouble----------------------- □ Yes □ No
Stomach trouble------------------- □ Yes □ No
Other illness-------------------------□ Yes □ No
Difficulty walking------------------ □ Yes □ No
Serious injuries--------------------- □ Yes □ No
Bleeding disorders----------------- □ Yes □ No
Lung Disease-------------------------□ Yes □ No
Kidney/bladder trouble------------ □ Yes □ No

Explain all "yes" answers: ____

____

List ALL operations and approximate date:

____
____
____

Current medications and dosage:

____
____
____

List ALLERGIES to medications------- ☐ **NONE**

____
____
____

FAMILY HISTORY

Heart problems--------------------- □ Yes □ No
Seizures----------------------------- □ Yes □ No
Bleeding disorders----------------- □ Yes □ No
Diabetes----------------------------- □ Yes □ No
Mental illness---------------------- □ Yes □ No
Other--------------------------------- □ Yes □ No
Arthritis------------------------------□ Yes □ No
Kidney/Bladder trouble------------□ Yes □ No

Explain all "yes" answers: ____

____

SOCIAL HISTORY

Number of people living in child's home _________________

How many are adults (number and relationship) ____

How many are brothers (number and ages) ____

How many are sisters (number and ages) ____

Other's (number and ages) ____

Grade in school ____

Smoke________ packs per day

Alcohol use------------------------- □ None □ Occasional

Illicit Drug use--------------------- □ None □ Presently □ Past

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

Roll over back to front-------------□ Yes □ No
Pull to a stand----------------------□ Yes □ No
Sit with support-------------------- □ Yes □ No
Walk independently--------------- □ Yes □ No
Crawl-------------------------------- □ Yes □ No
Run----------------------------------- □ Yes □ No

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

Stairs, one leg at a time------------□ Yes □ No
Hops on one foot------------------ □ Yes □ No
Stairs, alternating legs------------- □ Yes □ No
Skips--------------------------------- □ Yes □ No
Jumps------------------------------- □ Yes □ No

REVIEW OF SYSTEMS (Present NOW or Past 2 months)

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

Form Completed by____ Relationship______________________ Date_______________

Reviewed by____MD/PA-C Date____________________________