Pediatric Orthopedic & Scoliosis Medical Center

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(858) 966-6789 / FAX (858) 966-6706

Medical Information

Patient's Name:	Date of last visit:	Sex:	Age:________ yrs ______ mo

1. Reason for today's visit? ____________________
2. When did problem start? How often is it present? ____________________
3. The problem is now: ☐ better ☐ worse ☐ the same
4. Is there any pain? Location: ____________________ What makes it feel better? ____________________
5. What activites cause the problem? ____________________
6. Any previous treatment? ☐ No ☐ Yes How? ____________________
7. Family history of this or a similar problem? ☐ No ☐ Yes In Whom? ____________________
8. Past medical history: ***Please Explain All Yes Answers***
   - Major illnesses? ☐ No ☐ Yes ____________________
   - Prior hospitalizations? ☐ No ☐ Yes ____________________
   - Prior operations? ☐ No ☐ Yes ____________________
   - Current medications? ☐ No ☐ Yes ____________________
   - Allergies to medications? ☐ No ☐ Yes ____________________
   - Immunizations currrent? ☐ No ☐ Yes
9. Patient's birth history: Birth place (hospital) ____________________, (city) ____________________
   - Birth weight _______ lbs _______ oz
   - Premature? ☐ No ☐ Yes # Weeks gestation: ____________________
   - Problems with pregnancy? ☐ No ☐ Yes ____________________
   - Breech position? ☐ No ☐ Yes ____________________
   - Cesarean section? ☐ No ☐ Yes Why? ____________________
   - For mother: # of pregnancies ________ # of children ____________ # of this child ________
10. Developmental history:
    - Child sat up at ____________months
    - Child walked at ____________months
    - Child spoke at ____________months
11. Review of systems: Any problems with:
    - Fevers/Chills ☐ No ☐ Yes ____________
    - Ears, nose, throat ☐ No ☐ Yes ____________
    - Heart/vascular system ☐ No ☐ Yes ____________
    - Lung system ☐ No ☐ Yes ____________
    - Musculoskeletal system ☐ No ☐ Yes ____________
    - Urologic system ☐ No ☐ Yes ____________
    - Skin ☐ No ☐ Yes ____________
    - Neurologic system ☐ No ☐ Yes ____________
    - Endocrine system ☐ No ☐ Yes ____________
    - Blood diseases ☐ No ☐ Yes ____________
12. Social history:
    - Legal guardian of child: ☐ Mom ☐ Dad ☐ other: ____________
    - Grade in school: ____________________
    - Recreation/Sports: ____________________

____
Signature of person completing this form

____
Relationship to patient

____
Signature of person reviewing this form Date

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