Pediatric Orthopedics of Southwest Florida
Orthopedic Health History

Today's Date: _____

Name of Patient: _____ Patient's Date of Birth _____

Is your child a new patient? Yes No…if so, is this a new problem? No Yes

REASON FOR VISIT: _____

PAST MEDICAL HISTORY: None Yes…if so, please list child's prior and current illnesses and injuries.

_____

PAST SURGERIES OR HOSPITALIZATIONS: None Yes…if so, please provide procedures and dates performed.

_____

CURRENT MEDICATIONS: None Yes…if so, please list: _____

Name of Pharmacy you use: _____ Phone Number: _____

ALLERGIES to Medications, Foods, Latex, Other: No Yes…if so, please list _____

_____

FAMILY HISTORY (age and health status) Parents: _____

Siblings: _____

REVIEW OF SYSTEMS *(Please indicate if your child has a health problem in any of the following areas)*

No	Yes	System	Circle Conditions (if present)	*or*	Fill in for Other Conditions
☐	☐	Eyes	(Glaucoma, Glasses)		
☐	☐	Ears/Nose/Throat	(Deafness, Otitis, Sinusitis)		
☐	☐	Heart	(Murmur, Valve Defect)		
☐	☐	Lungs	(Asthma, Bronchitis, Tuberculosis)		
☐	☐	Abdomen	(Hepatitis, Colitis)		
☐	☐	Kidneys/Bladder	(Reflux, Incontinence, Infections)		
☐	☐	Muscles/Bones	(Fractures, Joint Problems)		
☐	☐	Skin	(Rashes, Eczema, Unusual Birth Marks)		
☐	☐	Neurologic	(Seizures, Headaches, Delay, Cerebral Palsy)		
☐	☐	Psychologic	(ADHD, Depression, Anxiety)		
☐	☐	Endocrine	(Diabetes, Thyroid Disease, Obesity)		
☐	☐	Hematologic	(Anemia, Sickle Cell, Leukemia, Lymphoma)		
☐	☐	Infectious/Inflammatory	(HIV, Recurrent Infections)		

BIRTH HISTORY

Born On Time? Yes No…if so, at how many weeks gestation was patient born? _____weeks

What was the birth weight? _____Pounds _____Ounces

Was patient born via C-Section? No Yes…if so, why? _____

Did baby present in the Breech position? No Yes

Were there any complications with the pregnancy/delivery? No Yes…if so, why? _____

DEVELOPMENTAL HISTORY

Age when first: Sat independently _____
Crawled _____
Walked _____
Talked _____

[Girls: Age at first menstruation? _____
What grade is your child in? _____
Hand your child writes with? Right Left
Involved in sports? No Yes…if so, please list:

_____

Most recent Height [_____feet_____inches] and Weight [_____pounds] of your child.

Does your child smoke? ___ No ___Yes

Additional Comments:

The past medical history and review of systems was reviewed by: _____