# PAST MEDICAL HISTORY

(Pediatric ≤18 years old)

Patient: _____ Preferred Pronouns: _____ Sex assigned at birth: _____

Date of Birth: _____ Age: _____ Right/Left hand dominant (Circle)

Family Doctor: _____

Who sent you to this office?: _____

WHY ARE YOU HERE TODAY?: _____

What are the **two best phone numbers** to reach you at: _____

_____

What date did your symptoms start/when did the injury occur?: _____

PAST MEDICAL HISTORY:

Birth History: Weeks at Delivery: _____ Delivery (circle): Vaginal /C-section, Due Date: _____

Reason and # of days hospitalized after birth: _____

Age child began walking: _____ Current Height: _____ Current Weight: _____

Major Accidents/Injuries (include dates): _____

Serious childhood illnesses or medical problems: _____

_____

PAST ORTHOPEDIC HISTORY (surgical and nonsurgical, include procedure, date, and surgeon):

_____

_____

MEDICATIONS AND SUPPLEMENTS (please list name and dose): _____

_____

ALLERGIES: _____

IMMUNIZATIONS: Up-to-date: _____Yes _____No

FAMILY HISTORY (Immediate family members' disease history such as scoliosis, childhood hip problems, diabetes, cancer, bleeding or clotting problems, major reactions to anesthesia, other): _____

_____

SOCIAL HISTORY: School: _____ Grade/Year: _____

Who do you live with?: _____

Interests/Activities: _____

Exercise/Sports/Athletic Participation: _____

PLEASE CIRCLE ANY PROBLEMS LISTED HERE IF YOUR CHILD HAS HAD IT AT ANY TIME

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|---|---|---|---|---|
| **MUSCULOSKELETAL** | Heart murmur | **ENDOCRINE** | Previous Cancer | **GYNECOLOGICAL** |
| Limb or joint pain | Rapid/abnormal pulse | Diabetes | Benign Tumor/Bump | Abnormal periods |
| Joint swelling | Other/None: _____ | Thyroid abnormalities | Other/None: _____ | Age periods started _____ |
| Back Pain | **CHEST/RESPIRATORY** | Weak bones/Osteoporosis | **NEUROLOGICAL** | Periods per year _____ |
| Walking problems | Asthma/Chronic Cough | Other/None: _____ | History of Concussion(s) | Date of last period _____ |
| Toes turned in/out | Shortness of breath | **GENITOURINARY** | Frequent Headaches | Pregnant now: Yes/No |
| Bow legs or knock knee | Positive TB test | Incontinence | Fainting or convulsions | Other/None: _____ |
| Juvenile arthritis | Other/None: _____ | Kidney/bladder infections | Dizziness or tingling | **SKIN** |
| Other/None: _____ | **EARS/NOSE/THROAT** | Other/None: _____ | Diffuse muscle weakness | Rash |
| **ALLERGIC** | Neck pain/stiffness | **GASTROINTESTINAL** | Tingling | Other/None: _____ |
| Allergies to medications | Hearing problems | Abdominal Pain | Bowel/bladder control | **CONSTITIUTIONAL** |
| Seasonal allergies | Sinus problems | Decreased appetite | Other/None: _____ | Fever/Chills |
| Food Allergies | Other/None: _____ | Hepatitis | **PSYCHIATRIC** | Night sweats |
| Other/None: ____ | **EYES** | Other/None: _____ | Psychiatric care | Weight loss/gain |
| **CARDIOVASCULAR** | Vision problems | **HEMATOLOGIC/TUMOR** | History of substance abuse | HIV/Exposure of HIV |
| High blood pressure | Other/None: _____ | Easy bruising/bleeding | Other/None: _____ | Other/None: ___ |

Patient or Parent Signature: _____ Provider Signature: _____ Date: _____