

# PEDIATRIC PATIENT HISTORY

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

Problem or complaint: \_\_\_\_\_

Duration: \_\_\_\_\_ Previous treatment or x-rays?: \_\_\_\_\_

Past History: List all surgeries and hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

## DEVELOPMENTAL HISTORY:

Birth Order: \_\_\_\_\_

Number of Siblings: \_\_\_\_\_

Full term pregnancy?: ( ) Yes ( ) No

Delivery: Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_

Any complications for mom or child during pregnancy or birth?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY: Please list foot, ankle, leg, knee and hip problems in the patient's immediate family, listing member's relation and current age:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother (s): \_\_\_\_\_

Sister (s): \_\_\_\_\_

Other Family: \_\_\_\_\_

SYSTEM REVIEW: Please check the appropriate spaces if the patient has a problem history in the corresponding area. Elaborate below.

Head \_\_\_\_\_ Heart \_\_\_\_\_ Abdominal Pain \_\_\_\_\_ Burning or Pain on Urination \_\_\_\_\_  
Eye \_\_\_\_\_ Lungs \_\_\_\_\_ Nausea \_\_\_\_\_ Bone or Joint Pain \_\_\_\_\_  
Ear \_\_\_\_\_ Asthma \_\_\_\_\_ Abnormal or Bloody Stools \_\_\_\_\_ Diabetes \_\_\_\_\_  
Nose \_\_\_\_\_ Bronchitis \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Cancer \_\_\_\_\_  
Throat \_\_\_\_\_ Stomach Ulcer \_\_\_\_\_ Liver Disease \_\_\_\_\_ Other \_\_\_\_\_

DOCTOR'S COMMENTS: \_\_\_\_\_

\_\_\_\_\_