Pediatric Orthopaedic Health History Questionnaire

DuPage Medical Group
WE CARE FOR YOU

PATIENT'S NAME ______________________

ACCOUNT NUMBER ______________________

PATIENT HISTORY

Please answer all questions as completely as possible. This will aid the doctor with the examination, will ensure a thorough history, and will expedite your visit. If any question is not applicable, please write N/A. Please have this with you for your appointment. We thank you for your patience.

DATE OF VISIT ______________________

PATIENT NAME ______________________

DATE OF BIRTH ____/____/____ AGE __________ GENDER: M F

Who referred you to this office? ______________________

Who is the patient's Primary Care Physician? ______________________

Physician's Phone Number: ______________________

CHIEF COMPLAINT

What health problem brings your child in today (the chief complaint)? ______________________

How long has the problem been present? ______________________

How did it start? Was there any injury or obvious cause? ______________________

Has there ever been a similar condition prior to this? Is there a similar condition elsewhere in the body?

Has any treatment been received? ☐ YES ☐ NO If yes, please explain: ______________________

Who prescribed it? ______________________ For how long? ______________________

Did the treatment help? ☐ YES ☐ NO ______________________

Item No. 1235A (Rev. 4/14)

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PRESENT HISTORY

PAIN

Does this patient have pain? ☐ YES ☐ NO

When is the pain most likely to occur? ☐ MORNING ☐ EVENING ☐ CONSTANT

☐ AWAKENS CHILD FROM SLEEP ☐ AT REST ☐ DURING PHYSICAL ACTIVITY

How long does the pain last? ____________________

What makes the pain worse? ____________________

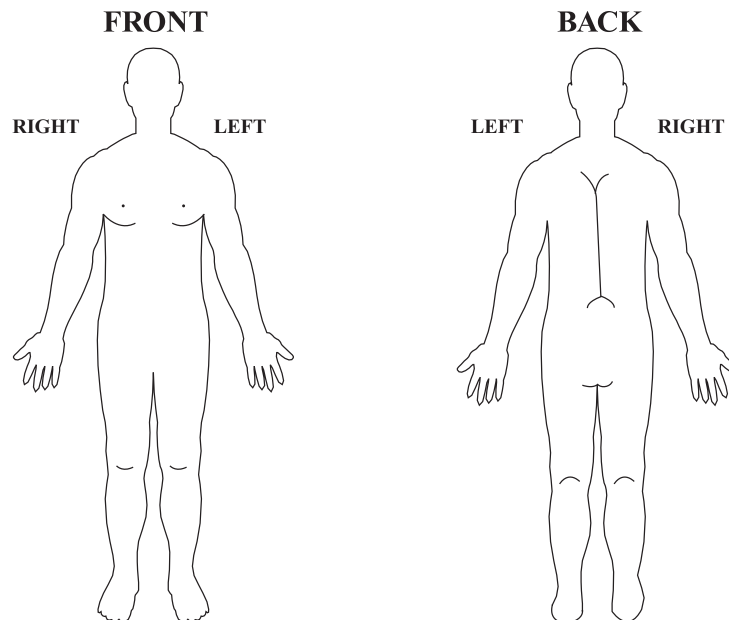
What relieves the pain (including medicines)? ____________________

____

Does the pain stay in one place or does it move? ____________________

____

Please indicate the site of the pain on the diagram below:



DEFORMITY

Please indicate areas of concern and give details

Spinal Deformity? ☐ YES ☐ NO

Do you see side-to-side curvature (scoliosis) or an excessively rounded back (kyphosis)? Please explain:

____

Limb Deformity? ☐ YES ☐ NO Please explain: ____________________

____

Foot Deformity? ☐ YES ☐ NO Are the feet? ☐ TURNED IN ☐ TURNED OUT ☐ FLAT

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PRESENT HISTORY (continued)

Does the patient limp? ☐ YES ☐ NO When and for how long? ______________________

____

Is there any joint swelling? ☐ YES ☐ NO

Is there limitation of motion of a joint (stiffness)? ☐ YES ☐ NO ______________________

____

Is there any difficulty with balance and coordination or with frequent falling? ☐ YES ☐ NO

Is there any difficulty with running and sports and keeping up with peers? ☐ YES ☐ NO

Please explain: ______________________

____

Does the child have any neuromuscular condition such as cerebral palsy, muscle or nerve disease? ☐ YES ☐ NO

____

Please add any further comments or concerns related to your child's condition not directly noted above?

____

____

____

X-RAYS

Have x-rays or other imaging tests (CT, MRI, or Ultrasound) been performed? ☐ YES ☐ NO

What part of the body was x-rayed? ______________________

____

Where and when was it performed? ______________________

____

Patient's current: Height ______________ Weight ______________

Please be sure to bring the actual films with you so that the doctor can review them. Radiologist's reports are frequently insufficient. Lack of access to tests already performed often unnecessarily delays diagnosis and treatment.

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PAST MEDICAL HISTORY

Birth Order. Where does the child fall in the order of his/her siblings (e.g. second of five) __________ of __________

Any problems with the pregnancy? ☐ YES ☐ NO ________________________________

Any problems with the delivery? ☐ YES ☐ NO ________________________________

Was the delivery at term? ☐ YES ☐ NO ______ wks.

Cesarean section? ☐ YES ☐ NO If yes, why? ________________________________

Breech position? ☐ YES ☐ NO

Birth Weight ________________________________

Did the baby have distress after the delivery? ☐ YES ☐ NO ________________________________

____

Milestones. Please recall when the child first:

sat independently: ________________________________

walked: ________________________________

Girls: Have menstrual periods begun? ☐ YES ☐ NO When was the first period? ______ / ______

Previous Hospitalizations ☐ YES ☐ NO

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Previous Surgeries ☐ YES ☐ NO

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Other serious medical problems, past or present? ________________________________

____

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List any medications, even non-prescription meds, and supplements that the child takes

Medication	Dose	Frequency	Reason

Medication Allergies

Medication	Year allergy discovered	Nature of Reaction (rash, hives, etc)

Are the child's immunizations current? ☐ YES ☐ NO

REVIEW OF SYSTEM

Please check any symptoms your child has and elaborate below

General ☐ FATIGUE ☐ WEIGHT LOSS ☐ LOSS OF APPETITE ☐ FEVER

Head, Ears, Eyes, Nose, Throat ☐ HEARING LOSS ☐ VISUAL LOSS ☐ STRABISMUS ☐ SORE THROAT

Skin ☐ RASHES ☐ UNUSUAL BIRTHMARKS

Endocrine Glands ☐ NECK MASSES ☐ CHANGE IN ENERGY LEVEL ☐ INTOLERANCE TO COLD

Respiratory ☐ SHORTNESS OF BREATH ☐ WHEEZING ☐ PERSISTENT COUGH

Cardiac ☐ CHEST PAIN ☐ HEART MURMUR

Gastrointestinal ☐ ABDOMINAL PAIN ☐ VOMITING ☐ CONSTIPATION ☐ DIARRHEA ☐ BLOODY STOOLS

Genitourinary ☐ PAIN ON URINATION ☐ LOSS OF BLADDER CONTROL

Neurological ☐ WEAKNESS ☐ NUMBNESS ☐ SEIZURES ☐ DIZZINESS ☐ HEADACHES ☐ HYPERACTIVITY/ADD ☐ DEVELOPMENTAL DELAY

FAMILY HISTORY

Please indicate if any of the following conditions are present in the family, and in whom

	Parents	**Siblings**
A condition similar to the patient's		
Juvenile Rheumatoid Arthritis		
A muscle or nerve condition, including muscular dystrophies		
Cerebral Palsy		
Chromosomal Disease		
Scoliosis or Spinal Deformity		
Congenital Deformities or Birth Defects		
Extreme Short or Tall Stature		

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SOCIAL HISTORY

Answer only those questions which apply to the child's age and situation as they relate to the child.

Does patient use any of the following assistive devices? ☐ GLASSES ☐ CONTACTS ☐ HEARING AIDES
☐ PROSTHETIC LIMBS ☐ CANE ☐ WALKER ☐ LEG BRACES

Smoking (Complete if age 13 and greater)

☐ CURRENT SMOKER ☐ FORMER SMOKER ☐ NEVER SMOKED

Current Smoker

How many cigarettes does the patient smoke per day?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How soon after patient wakes up do they smoke their first cigarette?

☐ Within 5 minutes ☐ 6-30 min ☐ 31-60 min ☐ after 60 min

Is the patient interested in quitting?

☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

Former smoker

How long has it been since patient last smoked?

☐ 1-3 months ☐ < 1 month ☐ 3-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ > 10 years

Does the patient use smokeless tobacco? (Complete if age 13 and greater)

☐ NO If patient quit smokeless tobacco, when did they quit? ______________________

☐ YES What does the patient use? ______________________ Number of years using smokeless tobacco? __________

Does the patient drink alcoholic beverages? ☐ NO ☐ YES—HOW OFTEN

☐ 1 DRINK PER MONTH ☐ 1-2 DRINKS PER WEEK ☐ 2-6 DRINKS PER WEEK ☐ 6 DRINKS OR MORE PER WEEK

Does the patient use recreational drugs? ☐ NO ☐ YES (Please list)

PLEASE PROVIDE**:**

Pharmacy Name: ______________________

Pharmacy Address: ______________________

Phone: ______________________ Fax: ______________________

Mail Order Pharmacy Name: ______________________

Mail Order Pharmacy Address: ______________________

Phone: ______________________ Fax: ______________________

THE ABOVE LISTED INFORMATION IS CORRECT TO THE BEST OF MY ABILITY:

PATIENT/PARENT SIGNATURE ______________________ DATE: __________