Children's Hospital LOS ANGELES
CHILDREN'S ORTHOPAEDIC CENTER

PAST MEDICAL HISTORY

(Pediatric ≤ 18 years-old)

Patient: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Gender (please circle): Male Female
Family Doctor (Please include phone # and address):_____
_____
Who sent you to this office?:_____
WHY ARE YOU HERE TODAY?: _____
_____

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

PAST MEDICAL HISTORY:

Serious Childhood Illnesses (include hospital stays and dates):_____
_____
_____
Major Accidents/Injuries (include dates): _____
Has the patient ever received a blood transfusion?: Yes_____ No____
Birth History: Weeks at Delivery: _____ Delivery(please circle):Vaginal delivery/C-section
Reason and # of days hospitalized after birth: _____
Age child began walking: _____ Current Height: _____ Current Weight: _____

PAST SURGICAL HISTORY: (include procedure, date and surgeon)_____
_____
_____

MEDICATIONS: (Please list name and dose)_____
_____

ALLERGIES:_____

IMMUNIZATIONS: Up-to-date: _____Yes ____No

FAMILY HISTORY: Father: Age_____ Mother: Age_____
Immediate family members' disease history: (Scoliosis, childhood hip problems, diabetes, cancer, other)_____
_____
_____
Has any family member had a major adverse reaction to anesthesia?: Yes_____ No____

SOCIAL HISTORY: School: _____ Grade/Year:_____
Who do you live with? _____
Interests/Activities: _____
Exercise/Sports/Athletic Participation: _____

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

MUSCULOSKELETAL
Limb or joint pain
-which joint? _____
-how often? _____
-when did it start? _____
Joint swelling
Back pain
Pain with activity
Pain at rest
Walking problems
In toeing (toes turned in)
Bow legs or knock knees
Juvenile rheumatoid arthritis
None of the above:_____

ALLERGIC/IMMUNOLOGIC
Allergies to medications
Seasonal allergies
Food allergies
None of the above:_____

CARDIOVASCULAR
High Blood Pressure
Shortness of breath
Rapid/abnormal pulse
Heart Murmur
Leg cramps with exercise
Poor Circulation
None of the above:_____

CHEST/RESPIRATORY
Chronic cough
Asthma
Has ever used oxygen
Sees Pulmonary doctor
Positive TB test
None of the above:_____

EARS, NOSE, MOUTH, THROAT
Neck pain/stiffness
Hearing problems
Ear infections
Sinus problems/sinusitis
None of the above:_____

EYES
Vision changes
Sensitivity to light
None of the above:_____

ENDOCRINE
Diabetes
Gout
Thyroid abnormality
Osteoporosis (weak bones)
None of the above:_____

GENITOURINARY
Blood in urine
Frequent/painful urination
Kidney/bladder infection
Incontinence
Difficulty urinating
None of the above:_____

GASTROINTESTINAL
Ulcers/Gastritis
Decreased appetite
Abdominal pain
Black bowel movements
Throw up blood
Hepatitis
None of the above:_____

HEMATOLOGIC/LYMPHATIC
Easy bruising/bleeding
Nose bleeds
Previous cancer
Previous tumor (benign)
Bump
Pain that awakens from sleep
None of the above:_____

NEUROLOGICAL
Frequent headaches
Fainting or convulsions
Dizziness or tingling
Diffuse muscle weakness
Tingling
Loss of bowel/bladder control
None of the above:_____

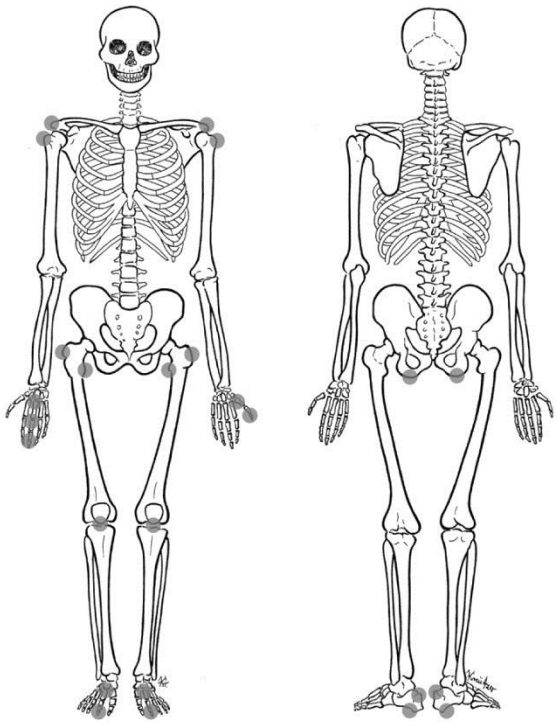
PSYCHIATRIC
Under psychiatric care
Psychiatric hospitalization
History of substance abuse
None of the above:_____

GYNECOLOGICAL
Abnormal/irregular periods
Age periods started: ____
How many periods per year: ___
Date of last period: _____
Pregnant now: Yes/No
None of the above:_____

SKIN
Rash
Burns
None of the above:_____

CONSTITUTIONAL
Fever/Chills
Night sweats
Weight loss
Excess weight gain or los
HIV/Exposure to HIV

Please use the diagrams below to indicate the symptoms your child has had recently. Use the key to indicate the type of symptoms.
Key: Pins and needles = 00000
Stabbing pain = /////
Burning feeling = xxxxx
Deep ache = zzzzz



Parent Signature_____
MD Reviewing Form: _____
Date: _____