

# Northern California Orthopedic Specialists

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## CHILD'S MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_ yr \_\_\_\_ mo Sex: M F

### Maternal and Neonatal History

This child was pregnancy number \_\_\_\_\_  
 Length of pregnancy \_\_\_\_\_  
 Prenatal complications:  
 None     Toxemia     Hemorrhage  
 Anemia     Diabetes     Other  
 Drugs taken during pregnancy \_\_\_\_\_  
 \_\_\_\_\_  Vitamin  
 Delivery in:  Hospital     Home  
 Other \_\_\_\_\_  
 Name of hospital \_\_\_\_\_  
  
 Type of delivery:  Normal     C Section  
 Abnormal (explain) \_\_\_\_\_  
 \_\_\_\_\_  
 Breech  
 Length of labor \_\_\_\_\_  
 Newborn:  
 Birth weight \_\_\_\_ lbs. \_\_\_\_ ozs.  
 APGAR \_\_\_\_ / \_\_\_\_  
 NICU? \_\_\_\_\_ How long? \_\_\_\_\_  
  
 Complications:  None  
 Difficult resuscitation     Meconium  
 Convulsions     Injury     Jaundice  
 Other \_\_\_\_\_  
 \_\_\_\_\_

### Developmental History

Sat Alone \_\_\_\_\_  
 Stood Alone \_\_\_\_\_  
 Walked Alone \_\_\_\_\_  
 Speech \_\_\_\_\_  
 Toilet Trained \_\_\_\_\_

### Family History

Brothers and sisters of patient

	Name	Age	Sex
1.	_____	_____	M F
2.	_____	_____	M F
3.	_____	_____	M F
4.	_____	_____	M F

### Patient Health History

Allergies:  None  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Medications:  None  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Previous Xrays:  
 Where done \_\_\_\_\_  
 \_\_\_\_\_  
 What was Xrayed \_\_\_\_\_  
 \_\_\_\_\_  
 When \_\_\_\_\_  
  
 Braces (legs, arms, back)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Operations:  None  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Hospitalizations:  None  
 \_\_\_\_\_  
 \_\_\_\_\_

### Family History

In child's parents or siblings:

	Yes	No
Club foot	<input type="checkbox"/>	<input type="checkbox"/>
Hip Defects	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent fractures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Other birth defects	<input type="checkbox"/>	<input type="checkbox"/>

Explain all yes answers:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Patient Health History

	Yes	No
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>
Frequent earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fevers	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Behavior problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent accidents	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>
Frequent fractures	<input type="checkbox"/>	<input type="checkbox"/>

### Sports Participation

1st Sport \_\_\_\_\_  
 Other sport \_\_\_\_\_

### Social History

School \_\_\_\_\_  
 Grade \_\_\_\_\_  
 Do both parents live at home?  
 Yes     No

### Physician

Primary \_\_\_\_\_  
 Referring \_\_\_\_\_  
 Why are you here today?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_