

Pediatric and Adolescent Orthopedics ▪ Trauma ▪ Sports Medicine ▪ Scoliosis ▪ Hip Disorders ▪ Clubfeet

Pediatric Patient Health Questionnaire

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Pediatrician: _____ Height: _____ Weight: _____

Reason for today's visit: _____

Any prior treatment (physical therapy, surgery, braces, etc.): _____

BIRTH HISTORY

How many weeks was the pregnancy: _____ Birth weight: _____

Any problems during the pregnancy, labor, or delivery: _____

Was delivery vaginal or c-section: _____ Was the child born head first or feet first: _____

Please indicate approximate age at which child first accomplished the goals below:

Sitting: _____ Crawling: _____ Walking: _____

MEDICAL PROBLEMS

____ Asthma ____ Seizures ____ Heart problems

Please list any other medical problems: _____

Does the child take any medications? (If yes, please list with dosage): _____

Does the child have any allergies to medications? (If yes, please list): _____

Has the child had any operations? (If yes, please list): _____

Are there any illnesses in the family? (If yes, please list): _____

School: _____ Grade: _____

Sports/activities/interests: _____

Parent/Guardian Signature: _____ Date: _____