Pediatric
THE ORTHOPEDIC CENTER

Pediatric 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:_____

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