MEDICAL HISTORY

Date / /

Patient Name_____ **DOB** / / **Age**_____ **Gender** M F
Pediatrician_____ **Orthopedist**_____
Reason for Visit (right/left)_____ **Date problem began** / /
Birth History Premature C-Section
Breech Problems with pregnancy/labor/delivery_____
Birth weight_____ Age Sat____ Age Walked____ Age Spoke____

Patient's Social History ☐ Lives with family ☐ guardian ☐ care facility ☐ group home

Patient's Family History ☐ back problems ☐ scoliosis ☐ neurological problems ☐ joint problems / ☐ arthritis ☐ bone deformities ☐ fibromyalgia

Has your child have any of these symptoms recently?

☐ fever	☐ chills	☐ nausea	☐ vomiting	☐ weight loss
☐ bleeding disorder	☐ fatigue	☐ visual problems	☐ sore throat	☐ ear ache
☐ shortness of breath	☐ rapid heart rate	☐ irritable bowels	☐ diarrhea	☐ weakness
☐ burning with urination	☐ night pain	☐ night sweats	☐ skin lesions	☐ joint pain
☐ joint swelling	☐ muscle pain	☐ abnormal gait	☐ tremors	☐ numbness

----------Please Stop Here----------

Height_____ Weight_____ OFC_____ Age of Menarche_____

PMH 1. 4.
2. 5.
3. 6.

PSH 1. 4.
2. 5.
3. 6.

MEDS (Rx, herbal, vitamins, over the counter) and reason for taking
1. 5.
2. 6.
3. 7.
4. 8.

Allergies
1. 3.
2. 4.