TOWSON ORTHOPAEDIC ASSOCIATES

Pediatric Medical Questionnaire

PATIENT NO. :

DATE:

Physician seeing today: _____ Date: _____

Child: _____ Parent: _____ Age: _____ Birthdate: _____

Address: _____

Check preferred # ❒ Home # _____ ❒ Cell # _____ ❒ Work # _____

Email: _____ Pharmacy: _____

Referring Physician/phone # _____ Primary Care Physician/phone # _____

Who referred you to the office today? _____

Height _____ **Weight / lbs.** _____ **Is this weight typical for you?** ❒ Yes ❒ No (more or less)

For women in childbearing years: ❒ pregnant now ❒ possibly pregnant but highly unlikely ❒ can't be pregnant

Check any allergies: ❒ None ❒ Penicillin ❒ Sulfa ❒ Aspirin ❒ Morphine ❒ Demerol ❒ Codeine ❒ Arthritis Drums ❒ Anesthesia Problems ❒ Latex Allergy ❒ Other (list) _____

Race*: ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American ❒ Multiracial ❒ Native Hawaiian ❒ Other Pacific Islander ❒ White ❒ Refused to Report/Unreported ❒ Undefined

Ethnicity*: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Refused to Report/Unreported ❒ Undefined

Preferred Language*: ❒ English ❒ Other: _____ **Do you smoke?** ❒ Yes ❒ No

Current Medical Problem:

Why are you seeking a medical evaluation today? _____

When did your symptoms begin? _____ Have you ever had this problem before? _____

How would you describe your pain? *(circle one)* Sharp Dull Aching Stabbing Throbbing

Do you have any of the following symptoms? *(circle if yes)* Locking Catching Painful Popping Instablility Swelling

What makes your pain worse? _____

What makes your pain better? _____

Does your pain radiate? _____

What have you done for treatment? _____

Have you seen any other physicians for this complaint? _____ Who? _____

Have you had any tests to evaluate this problem? _____

Past Medical History:

Have you ever been hospitalized? ❒ Yes ❒ No For What? _____

Please list any surgeries you have had: _____

Please list any medication you are taking below:

DRUG	DOSE	HOW OFTEN	FOR HOW LONG	PRESCRIBED BY

Family History: Please indicate if any family members have the following medical conditions:

_____ Bleeding problem _____ DVT _____ Pulmonary embolism _____ Osteoporosis

_____ Heart Problem _____ Gout _____ High blood pressure _____ Diabetes

_____ Kidney problem _____ Gastrointestinal problem _____ Thyroid Dz _____ Sudden Death

** Newly required information by the U.S. Department of Health and Human Services*

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Reviewing System: Please indicate if the patient has any of the following:

General Health

- *fever* ❒ No ❒ Yes
- *recent weight loss or gain (0.5 kg)* ❒ No ❒ Yes
- *more fatigue, tiredness than usual* ❒ No ❒ Yes

Ear, nose, throat (ENT)

- *infections, sinusitis* ❒ No ❒ Yes
- *pain, sore throat* ❒ No ❒ Yes
- *itchy nose, swollen glands in neck* ❒ No ❒ Yes

Ophthalmologic

- *decreased vision, itchy eyes* ❒ No ❒ Yes
- *pain in the eyes, discharge from the eye* ❒ No ❒ Yes
- *red eyes* ❒ No ❒ Yes

Pulmonary system

- *asthma* ❒ No ❒ Yes
- *cough* ❒ No ❒ Yes

Cardiac and Vascular system

- *chest pain* ❒ No ❒ Yes
- *passed out (syncope) with exercise* ❒ No ❒ Yes
- *high blood pressure* ❒ No ❒ Yes
- *irregular heartbeats* ❒ No ❒ Yes
- *heart murmur* ❒ No ❒ Yes

Gastrointestinal

- *heartburn* ❒ No ❒ Yes
- *nausea* ❒ No ❒ Yes
- *vomiting* ❒ No ❒ Yes
- *abdominal pain* ❒ No ❒ Yes
- *chronic diarrhea* ❒ No ❒ Yes
- *blood in stools* ❒ No ❒ Yes

Neurological

- *frequent headaches* ❒ No ❒ Yes
- *muscle weakness* ❒ No ❒ Yes
- *dizziness* ❒ No ❒ Yes
- *loss of sensation* ❒ No ❒ Yes
- *muscle cramps* ❒ No ❒ Yes
- *seizures* ❒ No ❒ Yes
- *history of concussions* ❒ No ❒ Yes

Urological

- *frequent urination* ❒ No ❒ Yes
- *groin/loin pain* ❒ No ❒ Yes
- *burning during urination* ❒ No ❒ Yes
- *kidney stones | disease* ❒ No ❒ Yes
- *testicular pain, mass, or irregularly* ❒ No ❒ Yes

Females only

- *pregnant* ❒ No ❒ Yes
- *menstrual irregularities* ❒ No ❒ Yes
- *missed, heavy periods* ❒ No ❒ Yes

Psychological

- *depression* ❒ No ❒ Yes
- *anxiety/excessive worry high level of stress* ❒ No ❒ Yes
- *difficulty staying/falling asleep* ❒ No ❒ Yes
- *history of eating disorders* ❒ No ❒ Yes

Hematological System

- *anemia* ❒ No ❒ Yes

Allergies

- *pollen* ❒ No ❒ Yes
- *foods* ❒ No ❒ Yes

Infection / Immunological

- *current infections* ❒ No ❒ Yes
- *recurrent infections* ❒ No ❒ Yes
- *HIV / AIDS* ❒ No ❒ Yes

Dermatological

- *skin rashes* ❒ No ❒ Yes
- *skin infections* ❒ No ❒ Yes
- *sun sensitivity* ❒ No ❒ Yes
- *allergies* ❒ No ❒ Yes
- *skin cancer* ❒ No ❒ Yes

Endocrine / Metabolic

- *diabetes mellitus* ❒ No ❒ Yes
- *thyroid gland disorders* ❒ No ❒ Yes
- *hypoglycemia (low blood sugar)* ❒ No ❒ Yes
- *more heat / cold intolerance than usual* ❒ No ❒ Yes

Social History:

School Name: _____ Grade in School: _____

Who lives with you at home? _____

Does your school have an athletic trainer? ❒ Yes ❒ No Name of Trainer: _____ Can we discuss injury ❒ Yes ❒ No?

What type of exercise or sport do you participate in? _____

List days a week that organized sports occur. _____

List number of hours per week each sport occurs. _____