University Hospitals
Case Medical Center

Division of Pediatric Orthopaedic Surgery

MEDICAL HISTORY FORM

Name: ____________________ DOB: ________ Grade in School: ________ Date: ____________

Legal Guardian(s): ____________________ Child lives with (names): ____________________

Pediatrician: ____________________ Address: ____________________ Phone: ____________

Referring Physician: ____________________ Address: ____________________ Phone: ____________

How did you hear about us? ☐ Referred by physician (name; address; phone no.) ____________________

____

☐ Referred by friend ☐ Internet Search ☐ Community Lecture
☐ Advertisement: ☐ Radio Ad ☐ Billboard ☐ Magazine Ad ☐ TV Program

Other ____

What is the reason for today's visit: ____

____

When did the problem first begin? ____

Problems during pregnancy/delivery (be specific) ____

Birthweight: ________ Age child rolled over: ________ Sat: ________ Walked: ________ Height: ________ Weight: ________

List past surgeries, fractures, illnesses or hospital stays: (if additional room is needed, add to back of page)

____

____

Reaction to any anesthesia? ____

Past medical problems: ____

____

Does the patient have or has ever had:

☐ Seizures (convulsions)
☐ Frequent headaches
☐ Problems with eyesight
☐ Problems hearing
☐ Bruise easily
☐ Heart murmur
☐ Asthma
☐ Recent cold/illness
☐ Kidney disease
☐ Liver disease
☐ Lung disease
☐ Stomach trouble
☐ Urinary problems
☐ Fever
☐ Growth problems
☐ Unexplained rashes or fevers

☐ Other (specify) ____

List any allergies: (medicine/food) ____

Medications: ____

Are there any conditions/illnesses that occur in your family (eg. Arthritis, heart disease, diabetes)? ____________________

____

Smoking: ________ Packs per day? ________ Drug or Alcohol use: ________ Emotional Problems: ____________________

FEMALES ONLY: Menstruation – age began: ________ Regular or irregular? ________ How many periods per year? ________

Patient/Legal Guardian Signature ____ Date: ____________

Physician Signature ____ Date: ____________

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