Pediatric Medical Information Questionnaire

*****This is important information which your doctor needs to know. Please provide as much detail as possible*****

Were you referred to this office? ❑ N ❑ Y *If so, by whom?* ______________________

Patient's Full Name ______________________ ❑ Female ❑ Male

Age _______ Date of Birth ____/____/____ Height _____/_____ Weight ___________

What is the main reason for this visit? ______________________

What body part is involved? ❑ Right ❑ Left ❑ Both ______________________

Accident Information If your injury is the result of an accident, where did it happen? ______________________

Date of Injury _____/_____/_____ How did the accident happen? ______________________

Have you been treated for this injury before? ❑ N ❑ Y By whom? ______________________ Where? ___________

Please describe your symptoms by checking all boxes that apply:

Pain ❑ N ❑ Y ❑ Other *Please describe* ______________________

Please rate your discomfort by circling: *None* = 0 1 2 3 4 5 6 7 8 9 10 = *Severe*

Where is the pain and how far does it extend to? ______________________

What is the quality of the pain? ❑ sharp ❑ dull ❑ throbbing ❑ burning ❑ other ___________

What is the duration of the pain? ❑ constant ❑ intermittent, off and on ❑ other ___________

When do symptoms occur? ❑ all day and night ❑ in the morning only ❑ during the day only ❑ at night only

❑ with activity *Please describe the activity* ______________________

What makes your symptoms better or worse? ______________________

Please give examples ______________________

Are you allergic to any medications? ❑ N ❑ Y Please list: ______________________

Are you currently taking any medications? ❑ N ❑ Y Please list: ______________________

Have you had any Surgeries or Hospitalizations? ❑ N ❑ Y *If so, please list here:*

Reason ______________________ Date____/_____ Doctor ___________

Reason ______________________ Date____/_____ Doctor ___________

Have you ever had a reaction to anesthesia? ❑ N ❑ Y

Authorization and Consent to Medical Services and/or Treatment

I hereby authorize the Doctor/Physician Assistant/Nurse Practitioner to provide medically necessary services,
including x-rays, fracture treatment, casting, or procedures done in the office,
which are determined to be in the best interest of the patient.

______________________ ***Date*** ______/______/______

Signature of Patient, or person authorized by law ***relationship to patient***

Reviewed for completeness by _______ ***MD signature*** ______________________ ***Date*** ______/______/______

Past & Present Illnesses or Injuries:

Do you have now or have you ever had:		***No***	***Yes***	***Current***	***Past***	***Year***	***Please describe***
CON:	fever, recent weight loss, loss of appetite	❑	❑	❑	❑	_____	______________________
EYES:	vision disturbance, glasses or contacts	❑	❑	❑	❑	_____	______________________
HENT:	hearing, ear, sinus or throat infection	❑	❑	❑	❑	_____	______________________
CVD:	heart disorder, murmur, high blood pressure	❑	❑	❑	❑	_____	______________________
RESP:	asthma, pneumonia, lung disorder, TB	❑	❑	❑	❑	_____	______________________
GI:	diarrhea, constipation, hepatitis, feeding tube	❑	❑	❑	❑	_____	______________________
GU:	Kidney, bladder, urinary disorder, catheter	❑	❑	❑	❑	_____	______________________
MS:	stiff or painful joints, arthritis, scoliosis	❑	❑	❑	❑	_____	______________________
IS:	rash, lumps, masses, skin disorder	❑	❑	❑	❑	_____	______________________
N:	seizures, numbness, weakness, a shunt	❑	❑	❑	❑	_____	______________________
P:	depression, mood or sleep disorder	❑	❑	❑	❑	_____	______________________
E:	thyroid disorder, diabetes, hypoglycemia	❑	❑	❑	❑	_____	______________________
H/L:	bleeding, bruising, anemia, enlarged glands	❑	❑	❑	❑	_____	______________________
Have you ever had rheumatic fever?		❑	❑	❑	❑	_____	______________________
Have you had any previous fractures or sprains?		❑	❑	❑	❑	_____	______________________
Have you ever had back or neck problems?		❑	❑	❑	❑	_____	______________________

Family History: Have any family members had any of the following disorders? If so, which relative?

Arthritis ❑ N ❑ Y ______________ Scoliosis ❑ N ❑ Y ____________________ Heart disease ❑ N ❑ Y ____________

Muscle disease ❑ N ❑ Y ___________ Diabetes ❑ N ❑ Y ___________ High Blood Pressure ❑ N ❑ Y ____________

Social History: Present grade in school ____________

Patient lives with: mother ❑ father ❑ both parents ❑ foster parents ❑ other ______________________

Legal guardian: mother ❑ father ❑ both parents ❑ foster parents ❑ the state ❑

Other children living in the home: brothers ❑ sisters ❑ their ages _____ _____ _____ _____ _____

Birth History: full term ❑ if not, # of weeks at delivery_______ C-section ❑ Vaginal ❑ Breech ❑

Complications, if applicable: ____

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Reviewed for completeness by ______ ***MD signature*** ____________________ ***Date*** ______/______/______