TOWSON ORTHOPAEDIC ASSOCIATES

Pediatric Medical Questionnaire

PATIENT NO. :

DATE:

Physician seeing today:_____ Date:_____

Child's Legal Name:_____ Child's Preferred Name:_____

Child's Sex at Birth:_____ Child's Preferred Gender:_____ Age:_____ Birthdate:_____

Parent/Guardian:_____ Relationship to Patient:_____

Best Contact Phone:_____ Email:_____

Referring Physician/Phone:_____ Primary Care Physician/Phone:_____

Who Referred you to the office:_____ Pharmacy:_____

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 *(If 18 years or older)*

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 _____ Inflammatory Arthritis (Lupus, Rheumatoid) _____ 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. _____

Patient Signature: _____ Date: _____

(IF UNDER 18 PARENT / GUARDIAN MUST SIGN)

Reviewed By: _____ , MD/CRNP/PA Date: _____