Locations:
Fort Worth
Dallas
Colleyville

PTFW
Business Office
817-247-1130
Fax: 817-292-7930
Tax ID #: 38-3707153

PEDIATRIC ORTHOPEDIC MEDICAL HISTORY

Patient's Name _____ ☐ M ☐ F Date _____
DOB_____ Age/Grade _____
Current Height_____ Current Weight _____
Diagnosis _____ Doctor _____
Person completing form _____
Relationship to patient_____

Please use back of sheets if more space is needed anywhere on this questionnaire.

CURRENT INJURY/PROBLEM

Date of injury/problem: _____ Date of Surgery: _____
Chief Complaint: _____
_____
What caused the problem? _____
_____
Previous Testing ☐MRI ☐CAT ☐X-Ray ☐Other _____
Results of Testing:_____
How does the current injury/problem affect daily functioning at home or school?_____
_____
_____

MEDICATION LIST

List all medications currently being taken (prescription, over the counter, vitamins, etc.)

_____ _____ _____
_____ _____ _____

List any adaptive equipment which is currently being used.

____Glasses ____Hearing aids ____Crutches
____Braces ____Wheelchair ____Walker
Other_____

What is your best learning style? (Check all that apply)

☐ Seeing ☐Listening ☐ Doing ☐Not Sure

GENERAL MEDICAL HISTORY

Please check yes or no to the following questions, and check whether it is related to the injury/problem. This will hep us understand present and past medical history. This information will maximize the safety and effectiveness of the evaluation and/or treatment and is strictly confidential.

ALL PATIENTS:

Do you have a heart murmur/heart valve problem?	☐Yes	☐No	
Do you have diabetes?	☐Yes	☐No	
Do you have bronchitis or asthma?	☐Yes	☐No	
Do you have a history of cancer or tumors?	☐Yes	☐No	
Have you ever had any blood disease?	☐Yes	☐No	
Do you wear contacts or hearing aids?	☐Yes	☐No	
Do you have ringing in your ears?	☐Yes	☐No	☐Injury related
Do you have any hearing problems/impairment?	☐Yes	☐No	☐Injury related
Do you have visual problems or impairment?	☐Yes	☐No	☐Injury related
Do you have swelling in your arms or legs?	☐Yes	☐No	☐Injury related
Do you have any fainting, dizziness, or light-headedness?	☐Yes	☐No	☐Injury related
Do you have any nausea or vomiting?	☐Yes	☐No	☐Injury related
Do you have any motion sickness?	☐Yes	☐No	☐Injury related
Do you have epilepsy, a history of seizures, or convulsions?	☐Yes	☐No	☐Injury related
Do you have difficulty swallowing?	☐Yes	☐No	☐Injury related
Do you have unusual or frequent headaches?	☐Yes	☐No	☐Injury related
Do you have extreme fatigue or loss of energy?	☐Yes	☐No	☐Injury related
Have you had any increase in thirst or hunger?	☐Yes	☐No	☐Injury related
Have you had any recent weight loss or weight gain? How Much?_____	☐Yes	☐No	☐Injury related
Have you ever had pain in your back?	☐Yes	☐No	☐Injury related
Have you ever had pain in your neck?	☐Yes	☐No	☐Injury related
Have you ever had pain in your pelvis?	☐Yes	☐No	☐Injury related
Have you had any fractured bones or joint dislocations?	☐Yes	☐No	☐Injury related
Do you have any metal implants?	☐Yes	☐No	☐Injury related
Do you have a fever or chills?	☐Yes	☐No	☐Injury related
Do you smoke? # pack/day____ # years ____	☐Yes	☐No	
Do you have a latex allergy?	☐Yes	☐No	
Do you have a rubbing alcohol allergy?	☐Yes	☐No	
Do you have other allergies? List _____	☐Yes	☐No	

If you answered "yes" to any of the above questions, please describe: _____

_____

_____

Female Patients:

Are you currently pregnant?	☐Yes	☐No
Do you have any problems with menstruation?	☐Yes	☐No

List all illnesses and injuries, and the age at which they occurred (i.e. chronic illnesses, asthma, seizures, allergies, etc.)_____

_____

_____

Have you been given any precautions related to the injury/problem or medication? _____

_____

Other Professional Evaluations:

Discipline	Name	Date	Results
Primary Doctor	_____	_____	_____
Orthopedist	_____	_____	_____
Neurologist	_____	_____	_____
Other	_____	_____	_____

List and give dates of any previous or current therapy programs:

Discipline	Agency	Date	Results
OT	_____	_____	_____
PT	_____	_____	_____
Other	_____	_____	_____

Concerning patient:

What is the best way to approach patient?_____

Please describe the problems(s) as you see it. _____

_____

How do you expect therapy to benefit this patient? _____

_____

Is there something you wish us to know that is not covered in the above portion of the questionnaire? _____

_____

_____

Parent's/Guardian's Signature/Date