

PEDIATRIC CASE HISTORY

DELIVERY/BIRTH HISTORY: _____

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND _____ FOLLOW AN OBJECT WITH HIS/HER EYES _____ HOLD HEAD UP _____
SIT ALONE _____ CRAWL _____ STAND _____ WALK ALONE _____

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKENPOX _____ MUMPS _____ MEASLES _____ RUBELLA _____
RUBEOLA _____ WHOOPING COUGH _____ OTHER _____

HAS THIS CHILD EVER SUFFERED FROM:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> ORTHOPEDIC PROBLEMS | <input type="checkbox"/> DIGESTIVE DISORDERS | <input type="checkbox"/> BEHAVIORAL PROBLEMS |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> NECK PROBLEMS | <input type="checkbox"/> POOR APPETITE | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> ARM PROBLEMS | <input type="checkbox"/> STOMACH ACHES | <input type="checkbox"/> RUPTURES/HERNIA |
| <input type="checkbox"/> SEIZURES/CONVULSIONS | <input type="checkbox"/> LEG PROBLEMS | <input type="checkbox"/> REFLUX | <input type="checkbox"/> MUSCLE PAIN |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> JOINT PROBLEMS | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> GROWING PAINS |
| <input type="checkbox"/> CHRONIC EARACHES | <input type="checkbox"/> BACKACHES | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> POOR POSTURE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> COLDS/FLU | <input type="checkbox"/> WALKING TROUBLE | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> BED WETTING | <input type="checkbox"/> OTHER _____ |

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- | | | |
|---|---|--|
| <input type="checkbox"/> FALL IN BABY WALKER | <input type="checkbox"/> FALL FROM BED OR COUCH | <input type="checkbox"/> FALL OFF SKATEBOARD OR SKATES |
| <input type="checkbox"/> FALL FROM CRIB | <input type="checkbox"/> FALL OFF SWING | <input type="checkbox"/> FALL OFF BICYCLE |
| <input type="checkbox"/> FALL FROM HIGHCHAIR | <input type="checkbox"/> FALL OFF SLIDE | <input type="checkbox"/> FALL DOWN STAIRS |
| <input type="checkbox"/> FALL FROM CHANGING TABLE | <input type="checkbox"/> FALL OFF MONKEY BARS | <input type="checkbox"/> OTHER _____ |

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? _____ IF YES, PLEASE EXPLAIN: _____

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? _____ IF YES, PLEASE EXPLAIN: _____

PRESENT HISTORY: _____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____

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