

# 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: \_\_\_\_\_