Medical City Children's Hospital
Orthopedics & Spine Specialists

For office use only:
W:_____H:_____T:_____

Established Patient History

Please answer all of the questions below regarding the patient's medical history since your last office visit

Patient Information:

Name: Date of Birth:

Medical History:
Since your last office visit, has the patient been diagnosed with any new medical conditions, been hospitalized, or undergone surgery?
☐ No ☐ Yes (If yes, please describe)

Medications:
Since your last office visit, has the patient started or discontinued any prescription medications, over-the-counter medications, vitamins, or supplements?
☐ No ☐ Yes (If yes, please list medication and dosage)

Allergies:
Since your last visit, has the patient developed any new allergies to medications or other materials?
☐ No ☐ Yes (If yes, please describe)

Social History:
Since your last visit, has the patient changed grades in school, changed school locations, or started/stopped any sports or other recreational activities?
☐ No ☐ Yes (If yes, please describe)

Review of systems:
In the last 3 months, has the patient experienced any new symptoms that were not present at your last office visit:

Fever:	☐ No ☐ Yes
Weight gain or loss greater than 5 pounds:	☐ No ☐ Yes
Difficulty seeing:	☐ No ☐ Yes
Difficulty hearing:	☐ No ☐ Yes
Chest pain:	☐ No ☐ Yes
Wheezing:	☐ No ☐ Yes
Constipation:	☐ No ☐ Yes
Pain with urination:	☐ No ☐ Yes
Rashes:	☐ No ☐ Yes
Anxiety:	☐ No ☐ Yes
Other:	☐ No ☐ Yes (If yes, please describe)

To the best of my knowledge, my answers are correct: _____ _____
Signature (Parent/Guardian) **Date**

_____ _____
Signature (Provider) Date

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