

PATIENT INFORMATION SHEET PEDIATRIC ORTHOPAEDICS

BACKGROUND Patient Name: _____ Date:_____ Ht:_____ Wt:____ Age: _____ □ MALE □ FEMALE Hobbies/Sports/Exercise Activities:_____ Primary Care Physician & Address: Physicians who follow your child regularly (neurologist, pulmonologist, etc.): Pharmacy name and address/phone number:_____ **REASON FOR VISIT** • Does your child have pain?

YES □ NO o If YES, what makes the pain better? O What makes the pain worse? ______ On a scale of 0-10, how severe is the pain? 0 1 2 3 4 5 7 8 9 10 No Pain Severe Pain What best describes the pain? (Check all that apply) ☐ Sharp/shooting \Box Achy \Box Dull \Box Cramping ☐ Burning ☐ Cramping ☐ Other (explain): _____ Was there an injury? ☐ Yes ☐ No If yes, please provide the date of injury:_____ What treatments has the child had so far? (Check all that apply) □ Ice □ Heat □ Brace □ Exercises □ Chiropractor _____ □ Other: _____ □ Medications (please list):_____ **CURRENT MEDICATIONS** (List name & dose of medication): **ALLERGIES** (Please list any known drug allergies) **SOCIAL HISTORY** Who lives with the child?

What grade in school is the child (if applicable)?

Does anyone who lives with the child smoke? _____



SURGICAL HISTORY: (1	List any past surgeries, including the	month/year of surgery)		
PAST MEDICAL HISTOR	RY: (Please choose all current and p	past medical conditions)		
□ No medical problems	□ Recurrent Ear Infections	□ Blood in Urine		
☐ High blood pressure	□ Pneumonia	☐ Swelling in Feet or Ankles		
□ Cancer	□ Shortness of Breath	☐ Kidney Problems/Stones		
☐ Heart surgery	☐ Migraine Headaches	□ Prior Broken Bones		
☐ Abnormal heart rhythm	□ Diabetes	□ Psychiatric Problems		
□ Seizures	□ Cerebral Palsy	□ Depression		
□ Vision/Eye Problems	□ Recurrent Skin Rashes	□ Rheumatoid arthritis		
□ Asthma	□ Reflux	□ Blood clots in legs/lungs		
□ Bronchitis	□ Gallbladder Disease	□ Other:		
FAMILY HISTORY: (Ind	icate conditions that run in the child'	s close family)		
<u>Condition</u>	<u>Relationship</u>	<u>Condition</u>	<u>Relationship</u>	
□ Clubfoot		☐ Osteogenesis Imperfecta		
□ Scoliosis		□ Ehlers Danlos Syndrome		
□ Marfan's Syndrome		□ Blood Clots		
□ Bleeding Disorders		☐ Hip dislocation as a child		
□ Other:				
REVIEW OF SYSTEMS:	Has the child experienced any of t	the following recently)		
General	Digestive	Psych	<u>Psychiatric</u>	
□ Unexplained weight loss	□ Nausea or vomiting	□ Depression	□ Depression	
□ Appetite change	□ Stomach pain or ulcer		□ Nervous exhaustion	
□ Fevers or chills	□ Heartburn/acid	□ Anxiety	□ Anxiety	
□ Night sweats	□ Frequent diarrhea	□ Paranoia		
□ Marked fatigue	□ Frequent constipation	□ Obsessive/o	□ Obsessive/compulsive behavior	
□ Difficulty sleeping	□ Uncontrolled loss of s	stool	•	
, ,	□ Blood in stool	Genitourinary		
Ear, Eyes, Nose, Throat	☐ Hemorrhoids		□ Burning on urination	
□ Difficulty swallowing		□ Difficulty starting urination		
□ Hoarseness	<u>Skin</u>		□ Incontinence	
□ Loss of hearing	□ Rashes		□ Pelvic pain	
□ Ear pain	□ Frequent itchiness	•	☐ Urinate at night more than once	
□ Nosebleeds	□ Easy bruising		. 8	
□ Gum trouble	□ Swollen ankles	Lung	Lung	
☐ Change of vision		□ Cough		
	Neurological	□ Shortness o	f breath	
Cardiovascular	□ Seizures	□ Productive cough or sputum		
☐ Heart or chest pain	□ Blackouts/fainting			
□ Abnormal heartbeat	□ Tremors			
□ Poor heart function	□ Headaches/migraines			