

SURGICAL HISTORY: (List any past surgeries, including the month/year of surgery)

PAST MEDICAL HISTORY: (Please choose all current and past medical conditions)

- | | | |
|--|---|---|
| <input type="checkbox"/> No medical problems | <input type="checkbox"/> Recurrent Ear Infections | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Swelling in Feet or Ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney Problems/Stones |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prior Broken Bones |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Vision/Eye Problems | <input type="checkbox"/> Recurrent Skin Rashes | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Reflux | <input type="checkbox"/> Blood clots in legs/lungs |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Other: _____ |

FAMILY HISTORY: (Indicate conditions that run in the child's close family)

<u>Condition</u>	<u>Relationship</u>	<u>Condition</u>	<u>Relationship</u>
<input type="checkbox"/> Clubfoot	_____	<input type="checkbox"/> Osteogenesis Imperfecta	_____
<input type="checkbox"/> Scoliosis	_____	<input type="checkbox"/> Ehlers Danlos Syndrome	_____
<input type="checkbox"/> Marfan's Syndrome	_____	<input type="checkbox"/> Blood Clots	_____
<input type="checkbox"/> Bleeding Disorders	_____	<input type="checkbox"/> Hip dislocation as a child	_____
<input type="checkbox"/> Other:	_____		

REVIEW OF SYSTEMS: (Has the child experienced any of the following *recently*)

- | | | |
|---|--|---|
| <p><u>General</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Appetite change <input type="checkbox"/> Fevers or chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Marked fatigue <input type="checkbox"/> Difficulty sleeping <p><u>Ear, Eyes, Nose, Throat</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Ear pain <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Gum trouble <input type="checkbox"/> Change of vision <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart or chest pain <input type="checkbox"/> Abnormal heartbeat <input type="checkbox"/> Poor heart function | <p><u>Digestive</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Stomach pain or ulcers <input type="checkbox"/> Heartburn/acid <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Frequent constipation <input type="checkbox"/> Uncontrolled loss of stool <input type="checkbox"/> Blood in stool <input type="checkbox"/> Hemorrhoids <p><u>Skin</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Frequent itchiness <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen ankles <p><u>Neurological</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Blackouts/fainting <input type="checkbox"/> Tremors <input type="checkbox"/> Headaches/migraines | <p><u>Psychiatric</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Nervous exhaustion <input type="checkbox"/> Anxiety <input type="checkbox"/> Paranoia <input type="checkbox"/> Obsessive/compulsive behavior <p><u>Genitourinary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Burning on urination <input type="checkbox"/> Difficulty starting urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Urinate at night more than once <p><u>Lung</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Productive cough or sputum |
|---|--|---|