URMC Orthopaedics and Rehabilitation

UNIVERSITY of ROCHESTER MEDICAL CENTER

Pediatric Orthopaedics New Patient History

Please answer the following questions about you or your child's health and life. If you need to change an answer that is already selected, please completely fill in that box and put an X through the correct answer(s). If you need any type of help, please ask.

For Staff Use Only:

(PUT LABEL HERE)

Patient's Name: _____ **Age:** ☐☐ years ☐☐ months

History of present illness:

Please tell us the story of the problem?

_____

_____

_____

_____

How did the problem begin?

☐ Developed over time ☐ Sports

☐ Birth ☐ Recreation

☐ Traffic accident ☐ Fall

☐ Unknown

☐ Other - explain _____

Please tell us the location and type of problem by checking the boxes below.

	Right						Left					
	Back	Arm	Leg	Neck	Foot	Hand	Back	Arm	Leg	Neck	Foot	Hand
Injury	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Deformity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stiffness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Giving Out	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Referring Doctor:

Mother's Name:

Father's Name:

Mother's Occupation:

Father's Occupation:

When did the problem start? (check one)

- ☐ On ☐☐ / ☐☐ / ☐☐☐☐
- ☐ Within the last week
- ☐ Within the last month
- ☐ Within the last year
- ☐ More than one year ago
- ☐ Since birth

Since the pain/condition began has it:

- ☐ Improved
- ☐ Not Changed
- ☐ Worsened
- ☐ Continued to come and go

What makes the problem worse?

- ☐ Activity
- ☐ Nothing in particular
- ☐ Certain positions
- ☐ Don't know
- ☐ Certain motions
- ☐ N/A
- ☐ Sports

What makes the problem better?

- ☐ Medicine
- ☐ Therapy
- ☐ Holding still
- ☐ Nothing in particular
- ☐ Walking
- ☐ Sports
- ☐ Different positions
- ☐ Don't know

Have you tried any of the following for the problem?

- ☐ Nothing
- ☐ Psychologist
- ☐ Physical therapy
- ☐ Holistic or alternative treatments
- ☐ Active exercise
- ☐ Medication
- ☐ Injections
- ☐ Chiropractor
- ☐ Surgery
- ☐ Other - explain

Were any of the following helpful in relieving the problem?

- ☐ None of these
- ☐ Psychologist
- ☐ Physical therapy
- ☐ Holistic or alternative treatments
- ☐ Active Exercise
- ☐ Medication
- ☐ Injections
- ☐ Chiropractor
- ☐ Surgery
- ☐ Other - explain

The following lines represent pain from no pain to the worst possible pain. Please make one mark on each of the lines below to describe your pain.

Your example pain:

No Pain ——|——————————————————| Worst possible pain

Pain right now:

No Pain ——————————————————— Worst possible pain

The average intensity of your pain this week:

No Pain ——————————————————— Worst possible pain

Pain at its worst:

No Pain ——————————————————— Worst possible pain

Pain at its least:

No Pain ——————————————————— Worst possible pain

Past history:

Birth:

☐ Normal (vaginal)
☐ Cesarean

Presentation:

☐ Head first (Vertex)
☐ Foot first (Breech)

Birth Weight:

☐☐ lbs ☐☐ oz

After delivery, were there complications?

☐ No
☐ Yes, please explain

_____

_____

Length of hospitalization after birth:

☐☐ days ☐☐ months

Development:

Age sitting: ☐☐ months ☐ Unable to do at this time

Age walking: ☐☐ months ☐ Unable to do at this time

For girls: when menstrual periods started:

Age: ☐☐ ☐ not yet

Has the patient had any of the following?

☐ X-rays ☐ MRI's ☐ Other studies ☐ Doctor visits
☐ None

If so, when, where, and who?

_____

_____

_____

_____

Has your child had any of the following?

☐ Physical therapy ☐ Bracing
☐ Occupational therapy ☐ Wheel chair
☐ Speech Therapy
☐ None

If bracing, what type?

☐ Foot orthotics ☐ Arm
☐ AFO ☐ Hand
☐ Knee ☐ Spine
☐ Hip

Social history:

School:

Current year (grade): ☐☐ ☐ Too young

Who does the patient live with?

☐ Living with mother
☐ Living with father
☐ Living with step mother
☐ Living with step father
☐ Living with grandparents
☐ Living with foster parents
☐ Living with ☐☐ sister(s)
☐ Living with ☐☐ brother(s)
☐ Other

Has the patient missed school or sports because of this problem?

☐ No ☐ Yes

Which Sport/s?

☐ Gym ☐ Baseball ☐ Basketball
☐ Dance ☐ Tennis ☐ Cross Country
☐ Soccer ☐ Swimming ☐ Hockey
☐ Football ☐ Horseback Riding ☐ Wrestling
☐ Lacrosse ☐ Track ☐ Cheerleading

Does the patient have any special needs in school?

☐ No

☐ Yes, please explain

Are any immediate family members deceased (parent, brothers, sisters)?

☐ No

☐ Yes, please explain

Allergies:

☐ No Known Allergies

☐ Penicillin	☐ Amoxicillin	☐ Gluten
☐ Seasonal allergens	☐ Eggs	☐ Grass/tress
☐ Sulfa Drugs	☐ Animal Dander	☐ Shellfish
☐ Environmental	☐ Soy	☐ Mold
☐ Dairy	☐ Dust	☐ Adhesive Tape
☐ Latex	☐ Bee Stings	
☐ Nuts	☐ Pollen	

Please list the name of any additional allergies:

Current Medications:

☐ No Medications

☐ Advair	☐ Dilantin	☐ Phenobarbitol
☐ Albuterol	☐ Flovent	☐ Prednisone
☐ Bactrim	☐ Ibuprofen	☐ Proventil
☐ Birth Control Pills	☐ Loratadine	☐ Singulair
☐ Clonidine	☐ MiraLax	☐ Tegretol
☐ Concerta	☐ Mupirocin	☐ Topamax
☐ Depakote	☐ Naproxen	☐ Ventolin
☐ Diastat	☐ Nasonex	☐ Vitamin

Please list the name of any additional medications:

Past medical history:

	Yes	No		Yes	No
Asthma	☐	☐	Muscle or nerve disease	☐	☐
Cerebral palsy	☐	☐	Diabetes	☐	☐
Heart disease	☐	☐	Thyroid disease	☐	☐
Kidney disease	☐	☐	Cancer	☐	☐
Bleeding disorder	☐	☐	Stomach or intestinal disorder	☐	☐
Autism	☐	☐	ADD/ADHD	☐	☐
Seizures	☐	☐	Other mental or neurological illness	☐	☐

Other:

Surgeries:

☐ No Surgeries

☐ Tonsillectomy	☐ Tubes in Ears	☐ Shunt Procedures
☐ Adenoidectomy	☐ Congenital Heart Surgery	☐ Hernia
☐ Appendectomy	☐ Nissen Fundoplication	☐ Broken Bones

Please list any additional surgeries:

Family medical history:

Does any one in the family have a similar problem to your child's problem(s)?

☐ No

☐ Yes, please explain:

Does any one in the family have the following?

	Yes	No	If yes, please explain:
Blood clots	☐	☐	
Problems with anesthesia	☐	☐	
Easy bleeding	☐	☐	
Other significant illness	☐	☐	

Review of Systems: Review of the patient's general health. Please check all that apply.

	Yes	No		Yes	No
Fever	☐	☐	**Weight gain**	☐	☐
Glasses	☐	☐	**Weight loss**	☐	☐
Problems hearing	☐	☐	**Choking**	☐	☐
Speech problems	☐	☐	**Drooling**	☐	☐
Circulation problems	☐	☐	**Ear, nose, throat obstruction**	☐	☐
Bone problems	☐	☐	**Difficulties breathing**	☐	☐
Muscle weakness	☐	☐	**Muscle pains**	☐	☐
Constipation	☐	☐	**Diarrhea**	☐	☐
Kidney infections	☐	☐	**Bed wetting**	☐	☐
Skin problems or rashes	☐	☐	**Incontinence**	☐	☐
Seizures or tremors	☐	☐	**Genital problems**	☐	☐
Behavioral problems	☐	☐	**Weakness**	☐	☐
Growth delay	☐	☐	**Numbness**	☐	☐
Easy bleeding or bruising	☐	☐	**Hormone problems**	☐	☐
Swollen glands	☐	☐	**Clotting or blood disorders**	☐	☐
Allergies	☐	☐	**Swollen arms or legs**	☐	☐
Vision problems	☐	☐	**Immune problems**	☐	☐

Thank you for completing this questionnaire!
Please remember to bring it to your appointment.

For Office Use Only:

Vital Signs (minimum of 3 entries required in Allscripts)

Height (cm): ☐☐☐.☐ Weight (kg): ☐☐☐.☐☐☐ Pulse: ☐☐☐

☐ Vital Signs recorded and reviewed in Allscripts

If unable to get weight or height, then obtain:

Head Circ (cm): ☐☐.☐ Temp (℃) ☐☐☐.☐ Respiration: ☐☐ Blood Pressure: ☐☐☐ / ☐☐☐

For Physician Use Only:

Reviewed and confirmed by:

Date ☐☐ / ☐☐ / ☐☐