



## 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?

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giving Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Referring Doctor:

Mother's Name:

Mother's Occupation:

Father's Name:

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?**

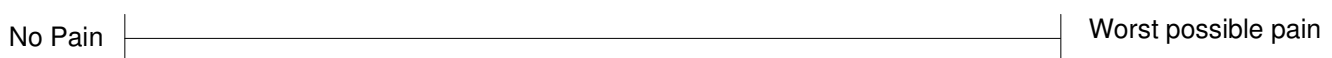
- None of these                       Psychologist
- Physical therapy       Holistic or alternative treatments
- Active Exercise       Medication
- Injections                       Chiropractor
- Surgery                       Other - explain

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.

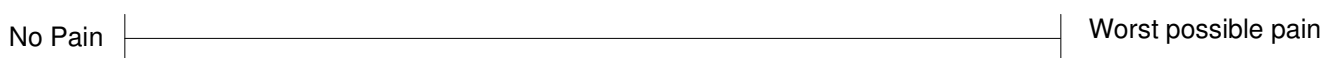
**Your example pain:**



**Pain right now:**



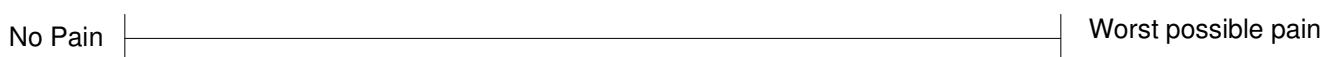
**The average intensity of your pain this week:**



**Pain at its worst:**



**Pain at its least:**



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

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

**Please list the name of any additional allergies:**

**Current Medications:**

- No Medications
- Advair
- Albuterol
- Bactrim
- Birth Control Pills
- Clonidine
- Concerta
- Depakote
- Diastat
- Dilantin
- Flovent
- Ibuprofen
- Loratadine
- MiraLax
- Mupirocin
- Naproxen
- Nasonex
- Phenobarbitol
- Prednisone
- Proventil
- Singulair
- Tegretol
- Topamax
- Ventolin
- Vitamin

**Please list the name of any additional medications:**

**Past medical history:**

	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or nerve disease	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or intestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Other mental or neurological illness	<input type="checkbox"/>	<input type="checkbox"/>

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:

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**Does any one in the family have the following?**

	Yes	No	If yes, please explain:
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Problems with anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other significant illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

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

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

**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: [ ][ ][ ]
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Vital Signs recorded and reviewed in Allscripts

If unable to get weight or height, then obtain:

Head Circ (cm): [ ][ ] . [ ]	Temp (°C): [ ][ ][ ] . [ ]	Respiration: [ ][ ]	Blood Pressure: [ ][ ][ ] / [ ][ ][ ]
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**For Physician Use Only:**

**Reviewed and confirmed by:**

Date [ ][ ] / [ ][ ] / [ ][ ]