Joe DiMaggio Children's Hospital | DEPARTMENT OF ORTHOPAEDIC SURGERY

Division of Pediatric Orthopedics and Spinal Deformities

Patient's Name (Nombre Y Apellido Del Paciente)	Place of Birth (Lugar De Nacimiento)	Social Security # (Seguro Social No.)	Sex (Sexo)	Date of Birth (Fecha De Nacimiento)	Today's Date (Fecha)

Local Address (Domicilio)	Apt # (Apto.)	City (Ciudad)	State (Estado)	Zip Code (Código Postal)	Phone (Teléfono)	Email

Mother's Name (Nombre de la madre)	Address (Dirección)	Phone (Teléfono)	Cell (Celular/)	Email

Mother's SS# (Seguro Social No.)	Birth Date (Fecha de nacimiento)	Employer (Empleador)	Position (Puesto)

Address Of Mother's Employer (Dirección)	Phone (Teléfono)

Father's Name (Nombre del padre)	Address (Dirección)	Phone (Teléfono)	Cell (Celular)

Father's SS# (Seguro Social No.)	Birth Date (Fecha de nacimiento)	Employer (Empleador)	Position (Puesto)

Address Of Father's Employer (Dirección del Empleador del Padre)	Phone (Teléfono)

Name Of Primary Care Physician (Nombre De Médico Primario)

-

Address (Dirección)	Phone # (Teléfono)

Preferred Pharmacy:	Preferred Pharmacy relative location (intersection, city):

Emergency Contact, Other Than Someone Living With You (Contacto De Urgencia, De Una Persona Que No Viva Con Usted) Name (Nombre Y Apellido) Phone# (Teléfono)	Relationship (Vínculo)

Home Address (Dirección)	City (Ciudad) State (Estado) Zip (Código Postal)

I Authorize The Release Of Any Payment & Medical Information Necessary To Process This Claim. The Information Provided On This Form Is True & Accurate To The Best Of My Knowledge. (Autorizo Pagos E Información Médica Necesaria Para Procesar Esta Reclamación. La Información Que Di En Este Formulario Es Válida Y Correcta A Mi Leal Saber.) I Have Received, Read And Understand My Patient "Rights & Responsibilities" and the "Hand & Respiratory Hygiene Education. (Recibí, Leí Y Entendí El Documento "Derechos De Los Pacientes y "Educacion para la higiene de las manos y vias respiratorias") I consent to Medical Care. (Yo autorizo ha recibir cuidados medico.)

Signature of Patient/Guarantor (Firma Del Paciente/Garante)

[Patient label here]

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Patient Name:

_____

Reason for today's visit:

_____

_____

Allergies:

_____

_____

List of Current Medications (include dose and frequency):

_____

_____

_____

_____

_____

Immunization Status:

Is the patient's immunization status up-to-date: (Please circle) yes or no

Patient/Family History

Perinatal History

Delivery - Complications	Yes No	Exposure-Substance	Yes No
NICU	Yes No	Complication - Diabetes	Yes No
If yes, how long?	_____	Complication - Bleeding	Yes No
Intracranial Hemorrhage	Yes No	Complication - Infection	Yes No
Ventilator	Yes No	Complication - Oligohydramnios	Yes No
Seizures	Yes No	Complication - Polyhydramnios	Yes No
Other:	_____	Complication - Other	Yes No

Birth History

Birth Information					
Birth Length:	_____	Birth Weight:	_____	Birth Head Circ.:	_____
Discharge Weight:	_____	Gestational Age:	_____	Delivery Method:	
Duration of Labor:	_____				
Hospital Information					
Days in Hospital:	_____	Hospital Name:	_____	Hospital Location:	_____
APGAR Scores					
APGAR 1:	_____	APGAR 5:	_____	APGAR 10:	_____
Feeding					
Method:					

[Patient label here]

Developmental History

Age rolling over back to front _____

Age at walking _____

Other: _____

Age at sitting _____

Age of first menstral cycle _____

Does the patient currently wear braces? Yes No

Patient's Social History

Patient lives with: Mother | Father | Mother and Father | Legal Guardian | Alone | Spouse | Other Family | Other

Divorced: Yes | No

Current grade in school: Pre-school | Kindergarden | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | College | Postgraduate School

Is the child in day care: Yes | No

Adopted: Yes | No

Brothers: 0 | 1 | 2 | 3 | 4 | 5+

Sisters: 0 | 1 | 2 | 3 | 4 | 5+

Patient's Medical/Surgical History

Medical Illnesses & Hospitalizations:

_____

_____

_____

Chronic Conditions:

_____

_____

_____

Previous Surgery:

_____

_____

_____

Family History (Write Yes or No and Indicate Relationship)

Anesthesia allergies_____
Benign Bone Tumor_____
Bleeding Disorder_____
Bone Cancer_____
Cancer_____
Diabetes _____
Gait Abnormality_____
Heart Failure_____
Hypertension_____
Immunodeficiency_____
Neurological Problems_____
Rheumatoid Arthritis_____
Scoliosis_____
Short Stature_____

Patient's Substance and Sexual History

Please fill out if patient is 13 years of age or older
(Circle Yes or No for each item below)

- **Patient Tobacco Use:** Yes or No
- **Tobacco Use of House Hold Member:** Yes or No
- **Patient Alcohol Use:** Yes or No
- **Patient Drug Use:** Yes or No
- **Is the Patient Sexually Active:** Yes or No

Review of Systems

Please **check the box** if the patient is experiencing any of the below symptoms or conditions.

[Patient label here]

Constitutional	☐ Unexplained weight gain ☐ Unexplained weight loss ☐ Feeding Problems ☐ Recent fever (above 100 degrees)
Gastrointestinal	☐ Diarrhea ☐ Vomiting
Cardiovascular	☐ Unexplained arm or leg swelling ☐ Heart murmurs ☐ High blood pressure
Allergic/Immunologic	☐ Environmental allergies or hives.
Genitourinary	☐ Bladder infection ☐ Inability to control urine ☐ Constipation ☐ Kidney infection
Musculoskeletal	☐ Back pain ☐ Joint pain ☐ Recent fall or injury
Eyes	☐ Visual Problems
Hematologic/lymphatic	☐ Bleeding problems ☐ Bumps or knots under the arm or in groin ☐ Easy bruising ☐ Low blood count
Neurological	☐ Seizures ☐ Head trauma
HENT	☐ Recurrent infection of ears/nose/throat ☐ Frequent nosebleeds
Respiratory	☐ Asthma
Skin	☐ Rashes ☐ Birth marks
Endocrine	☐ Known problem with diabetes ☐ Known problem with thyroid ☐ Known problem with growth hormone
Psychiatric/Behavioral	☐ Learning issues at school ☐ Depression ☐ Behavioral problems ☐ Attention deficit disorders

☐ **Check here if the patient is not experiencing any symptoms or conditions today**

[Patient label here]