Joe DiMaggio Children's Hospital | DEPARTMENT OF ORTHOPAEDIC SURGERY

Division of Pediatric Orthopedics and Spinal Deformities

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

[Patient label here]

Review of Systems

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

Constitutional	☐ Unexplained weight gain ☐ Unexplained weight loss ☐ Feeding Problems ☐ Recent fever (above 100 degrees)
Gastrointestinal	☐ Diarrhea ☐ Vomitting
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]