OK Orthopedics for Kids

New Patient History

Patient's Name:_____Date of Birth:_____
Primary Care Physician:_____
Reason for visit _____
_____
Drug Allergies(Circle or List):NONE / _____
Child's Birth History (Check One): Biologic_____, Adopted_____, Step Child_____
Any complications at delivery: (Circle or List):NONE /
_____
Child's Prior Surgeries & Hospitalizations: (Circle or List):NONE /
_____
_____
Child's Current Medications(Circle or List):NONE /

1.	3.	5.
2.	4.	6.

Has your child experienced any of the following:

Y N ADD/ADHD	Y N Eye Problems	Y N Numbness/Tingling
Y N Anxiety/Depression	Y N Fatigue	Y N Pneumonia
Y N Asthma	Y N Feeding Difficulties	Y N Rash
Y N BiPap/Oxygen	Y N Fever (recent greater than 102)	Y N Reflux
Y N Blood Disorder/Sickle Cell/Anemia	Y N Growth Hormone Therapy	Y N Speech Problems
Y N Congenital Heart Disease	Y N Hearing Loss	Y N Swollen Joints
Y N Constipation/Diarrhea	Y N Heart Murmur	Y N Toe Walking
Y N Coordination/Balance Problems	Y N HIV	Y N Tuberculosis
Y N Cystic Fibrosis	Y N Hypo/Hyperthyroidism	Y N Weight Loss/Weight Gain
Y N Developmental Delay	Y N Incontinence	Y N Pain Where?_____
Y N Diabetes	Y N Latex Allergy	Y N Menstrual Cycle:
Y N Epilepsy/Seizures	Y N Migraine Headaches	Regular Irregular

Comments or Additional History:_____
_____
_____
Please list any other specialists or therapists that currently care for your child:
_____
_____

Family History:

Y N Ankylosing Spondylitis	Y N Heart Disease	Y N Osteoarthritis
Y N Blounts Disease	Y N High Blood Pressure	Y N Osteogenesis Imperfecta
Y N Club Feet	Y N Lupus	Y N Rheumatoid Arthritis
Y N Dislocated hip	Y N Neurofibromatosis	Y N Scoliosis

Comments or Additional History:_____
_____
_____
Mother's Age _____years Health: Good/Fair/Deceased/Unknown
Father's Age _____years Health: Good/Fair/Deceased/Unknown
Brothers/Sisters of the patient
Male/Female age_____years Health: Good/Fair/Deceased/Unknown
Male/Female age_____years Health: Good/Fair/Deceased/Unknown
Male/Female age_____years Health: Good/Fair/Deceased/Unknown
Male/Female age_____years Health: Good/Fair/Deceased/Unknown

Social History:
Child lives in home with: _____Mother _____ Father _____Other: _____
Does your child smoke? Y N use alcohol? Y N Does anyone in the home smoke? Y N
School_____Grade_____
Signature:_____Relationship to Patient:_____Today's Date:_____

Reviewed by:_____, MD Date:_____