

# New Pediatric Patient Information Form

## Alpine Orthopaedic Medical Group

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Who sent your child to see the orthopaedic surgeon today? \_\_\_\_\_

Name of pediatrician or family doctor: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_ Child's Age: \_\_\_\_\_ (years) \_\_\_\_\_ (months)

Male /  Female

Right-handed /  Left-handed

What is your child's problem? (The reason you are here today) \_\_\_\_\_

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When did the problem begin? \_\_\_\_\_

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How did the problem begin? (If the problem is an injury, please describe) \_\_\_\_\_

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Describe treatment up to now and approximate date: \_\_\_\_\_

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Is the problem: Getting better - Getting worse - Staying the same? (circle one)

**Family History:**

					Height	Weight
Father Age: _____	Health: <input type="checkbox"/> good	<input type="checkbox"/> fair	<input type="checkbox"/> poor		_____	_____
Mother Age: _____	Health: <input type="checkbox"/> good	<input type="checkbox"/> fair	<input type="checkbox"/> poor		_____	_____
Siblings:						
Age: _____	Sex: M / F	Health: <input type="checkbox"/> good	<input type="checkbox"/> fair or poor		_____	_____
Age: _____	Sex: M / F	Health: <input type="checkbox"/> good	<input type="checkbox"/> fair or poor		_____	_____
Age: _____	Sex: M / F	Health: <input type="checkbox"/> good	<input type="checkbox"/> fair or poor		_____	_____
Age: _____	Sex: M / F	Health: <input type="checkbox"/> good	<input type="checkbox"/> fair or poor		_____	_____

Have **your** blood relatives had any of the following? (circle all that apply)

- |   |  |              |                       |
|---|--|--------------|-----------------------|
| allergies   | congenital abnormalities/birth defects | club foot    | high blood pressure   |
| asthma  | blood dyscrasia/bleeding disorder      | diabetes     | heart disease         |
| epilepsy  | kidney disease                         | cancer       | arthritis and/or gout |
| scoliosis   | complications of surgery or anesthesia | tuberculosis |                       |
| congenital hip dislocation/congenital hip dysplasia |  |              |                       |

**Social Background (Child):**

Present grade in school: \_\_\_\_\_ Special Education: \_\_\_\_\_

Sports Activities: \_\_\_\_\_

Have you ever lived outside the United States?  Yes  No

If yes, where and for how long? \_\_\_\_\_

Current residence: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Birth Data:** Birthplace (hospital, city) \_\_\_\_\_

Term  Pre-Term  (no. of weeks \_\_\_\_\_) Vaginal  C-Section   
Reason for C-Section \_\_\_\_\_

Complications during pregnancy or delivery \_\_\_\_\_

Birth Weight \_\_\_\_\_ Newborn Problems \_\_\_\_\_

**Development:**

Is your child:  Shorter than average  Average height  Tall for age

(Age 5 and under)

At what age did your child: Sit \_\_\_\_\_ Walk \_\_\_\_\_ Speak clearly \_\_\_\_\_

(Age 5 and older)

How does your child perform in school?  Below average  Average  Above average  
Development:  Normal  Advanced  Slow

(Adolescents)

Female: When was the onset of menstrual period? Age: \_\_\_\_\_ Date: \_\_\_\_\_

**Past Medical History:**

Serious illnesses (and dates) \_\_\_\_\_

Hospitalizations (age, reason): \_\_\_\_\_

Prior Surgery (procedure and date): \_\_\_\_\_

Does your child take any medication?  Yes  No

If yes, please list: \_\_\_\_\_

Allergies to medications?  Yes  No

If yes, please list \_\_\_\_\_

Does your child have a latex allergy?  Yes  No

Asthma?  Yes  No Exposure to Tobacco Smoke?  Yes  No

Immunizations up-to-date?  Yes  No

**Review of Systems:**

Is your child easily fatigued?

Had unexplained weight loss or gain?

Has your child ever had a heart murmur?

Does your child have difficulty exercising?

Has your child ever had a seizure?

Is the child potty-trained?

Does your child have weakness in any limbs?

Does one limb look smaller than the other?

Does your child have any birth defects?

**Additional Comments / Information:**

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