UFHealth PHYSICIANS

NEW Patient Pediatric Orthopaedic and Sports Medicine Medical History Form

Patient's Name_____ Today's Date_____

Date of Birth _____ Age _____ Grade _____ School _____

Sports Played_____

Referring Physician _____

Primary Care Physician _____

Legal guardian_____ Who Does child live with _____

What is the Reason for Today's Visit? _____

_____

When Did the Problem First Begin? _____

Any Previous Evaluation for this problem? :

Doctor visits **Y** or **N** (name and the date) _____
X-rays **Y** or **N** (name and the date) _____
CT **Y** or **N** (name and the date) _____
MRI **Y** or **N** (name and the date) _____
Ultrasound **Y** or **N** (name and the date) _____
Lab Tests **Y** or **N** (name and the date) _____
Other Studies **Y** or **N** (name and the date) _____

Any Previous Treatment for this problem? :

Physical Therapy **Y** or **N** (name and the date)_____
Surgery **Y** or **N** (name and the date)_____
Bracing/Orthotics **Y** or **N** (name and the date)_____
Other Treatment **Y** or **N** (name and the date)_____

Past Medical History

List past Medical Problems

_____

_____

List past Surgeries, Fractures and/or Hospital Stays _____

_____

_____

List any medications Being Taken _____

_____

List any medical problems that run in your family _____

_____

_____

PLEASE TURN OVER AND COMPLETE

Past Medical HX cont.

Does anyone in the family:

Smoke Y or N (who) _____

Use drugs/alcohol Y or N (who) _____

Have emotional problems Y or N (who) _____

Birth History

Birth-weight _____ Age when child rolled over _____ Sat _____ Walked _____

Any problems During Pregnancy? Y or N (what) _____

Any Problems during labor/delivery? Y or N (what) _____

Female Patients :

Age when menses began _____ Regular/Irregular _____ How many periods per year _____

Have you ever stopped getting your period for more than 3 months at a time? **Y** or **N**

Review of systems

Please check the appropriate box regarding these symptoms:

	Currently Has	Had in past	Never Had
Fevers/Chills	{ }	{ }	{ }
Weight Loss	{ }	{ }	{ }
Recent Cold/Illness	{ }	{ }	{ }
Ear Problems	{ }	{ }	{ }
Nose Problems	{ }	{ }	{ }
Mouth or Throat Problems	{ }	{ }	{ }
Heart Murmur	{ }	{ }	{ }
Chest Pain	{ }	{ }	{ }
Passing Out	{ }	{ }	{ }
Asthma	{ }	{ }	{ }
Lung or Breathing Problems	{ }	{ }	{ }
Stomach Problems	{ }	{ }	{ }
Diarrhea	{ }	{ }	{ }
Kidney Disease	{ }	{ }	{ }
Liver Disease	{ }	{ }	{ }
Urinary Problems	{ }	{ }	{ }
Skin Problems/Rash	{ }	{ }	{ }
Frequent Headaches	{ }	{ }	{ }
Seizures	{ }	{ }	{ }
Concussion	{ }	{ }	{ }
Neurologic Problems	{ }	{ }	{ }
Psychiatric Problems	{ }	{ }	{ }
Bleeding Disorder	{ }	{ }	{ }
Blood Problems	{ }	{ }	{ }
Sickle Cell disease	{ }	{ }	{ }
Allergies	{ }	{ }	{ }
Joint Swelling	{ }	{ }	{ }
Autoimmune Problems	{ }	{ }	{ }
Unexplained Rashes/Fever	{ }	{ }	{ }