Midwest Orthopaedic Center, SC

New Patient: Pediatric

MIDWEST ORTHOPÆDIC CENTER

Name:_____ Date: _____

Birthdate: _____ Height___ft.___in. Weight_____lbs.

A. General Information

1. Referring doctor name and full address: _____

_____

If not referred, how did you choose this office? _____

2. Internist or family doctor name and address: _____

_____

3. Briefly describe the reason for this visit: _____

_____

4. Your age: ___years ___ months

5. Your sex: ❑ male ❑ female

6. How long has your problem been present? _____

7. Has your problem worsened recently? ❑ no ❑ yes — How recently? _____

_____

8. What started the problem?_____

_____

9. Who is/are the patient's primary caregiver(s)? _____

10. What is your relationship to the patient? _____

B. Medical History: Check all that apply

❑ Heart attack
❑ Heart failure
❑ High blood pressure
❑ Osteoarthritis
❑ Rheumatoid arthritis
❑ Ankylosing spondylitis
❑ Gout
❑ Osteoporosis
❑ Other: _____

❑ Diabetes
❑ Stroke
❑ Seizures
❑ Mental illness
❑ Kidney stones
❑ Kidney failure
❑ Cancer
❑ Stomach ulcers

❑ None apply
❑ Lung disease
❑ HIV
❑ AIDS
❑ Tuberculosis
❑ Asthma
❑ Blood clot in leg
❑ Blood clot in lung

❑ Liver trouble
❑ Hepatitis
❑ Thyroid trouble
❑ Bleeding disorders
❑ Anemia
❑ Serious injuries [explain]

C. Review of Systems: Check all that apply

❑ None apply

❑ Reading glasses
❑ Change of vision
❑ Loss of hearing
❑ Ear pain
❑ Hoarseness
❑ Nosebleeds
❑ Difficulty swallowing
❑ Morning cough
❑ Shortness of breath
❑ Fever or chills
❑ Heart or chest pain
❑ Abnormal heartbeat
❑ Swollen ankles
❑ Calf cramps with walking
❑ Poor appetite
❑ Toothache
❑ Gum trouble
❑ Nausea or vomiting
❑ Stomach pain
❑ Ulcers
❑ Frequent belching
❑ Frequent diarrhea
❑ Frequent constipation
❑ Hemorrhoids
❑ Frequent urination
❑ Burning on urination
❑ Difficulty starting urination
❑ Get up more than once every night to urinate
❑ Frequent headaches
❑ Blackouts
❑ Seizures
❑ Frequent rash
❑ Hot or cold spells
❑ Recent weight change
❑ Nervous exhaustion
❑ Other _____

D. Family History: Check all that apply

❑ None apply

❑ Stroke
❑ Heart trouble
❑ High blood pressure
❑ Diabetes
❑ Arthritis
❑ Gout
❑ Seizures
❑ Spine problems
❑ Mental illness
❑ Kidney trouble or stones
❑ Cancer
❑ Bleeding disorders
❑ Scoliosis
❑ Other _____

E. Medications you take: ❑ None

_____

_____

_____

F. Surgical History: Previous surgeries — List procedures, surgeon and date. ❑ None

Operation	Surgeon	Date

G. Allergies: ❑ No known drug allergies

Latex allergy? _____

Medication	Rash	Swelling wheezing or shock	Upset stomach	Unknown reaction	Other
	❑	❑	❑	❑	
	❑	❑	❑	❑	
	❑	❑	❑	❑	
	❑	❑	❑	❑	
	❑	❑	❑	❑	

Food allergy? _____

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H. Birth History:

At how many weeks in the pregnancy was the patient born (gestational age)? _____weeks (Full term: 40 weeks)

Birth weight: _____ pounds _____ ounces

Were there any complications with the pregnancy? ❑ no ❑ yes — please explain

_____

Were there any complications with the delivery or during hospitalization? ❑ no ❑ yes — please explain

_____

I. Social History:

Grade in school:

Is the patient involved with any school activities or organized sports? ❑ no ❑ yes — please list

_____

Number of siblings: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ _____

I live with: _____

Tobacco use: ❑ Never ❑ Chew ❑ Cigarettes

Alcohol: ❑ Never ❑ Occasional

Drug overuse/abuse: ❑ Never ❑ Currently ❑ In the past

J. Developmental History:

Are there any concerns from the child's school or physician regarding his/her development? ❑ no ❑ yes

Has the patient reached all of his/her milestones at an appropriate time? ❑ no ❑ yes

Age when sitting: _____

Age when walking: _____

For female patients:

Has the patient starter her menstrual cycles? ❑ no ❑ yes — date of first menstrual period [month and year]: _____

K. For Patients with <u>Back or Leg Pain</u>, numbness or weakness:

(If you are seeing the doctor for neck problems, please complete section **"L"**)

1. What percent [%] of your pain is back pain and what percent [%] is leg or buttock pain (check appropriate box):

❑ Back 0%, leg 100% ❑ Back 10%, leg 90% ❑ Back 25%, leg 75% ❑ Back 40%, leg 60%
❑ Back 50%, leg 50% ❑ Back 60%, leg 40% ❑ Back 75%, leg 25% ❑ Back 90%, leg 10%
❑ Back 100%, leg 0%

2. There is: ❑ no leg pain ❑ leg pain present in the (check the following):
   Right: ❑ buttock ❑ thigh-front ❑ thigh-back ❑ calf ❑ foot
   Left: ❑ buttock ❑ thigh-front ❑ thigh-back ❑ calf ❑ foot
3. There is: ❑ no weakness of the legs ❑ weakness of the (check the following):
   Right: ❑ thigh ❑ calf ❑ ankle ❑ foot ❑ big toe
   Left: ❑ thigh ❑ calf ❑ ankle ❑ foot ❑ big toe
4. There is: ❑ no numbness of the legs ❑ numbness of the (check the following):
   Right: ❑ thigh ❑ calf ❑ foot
   Left: ❑ thigh ❑ calf ❑ foot
5. The worst position for the pain is: ❑ sitting ❑ standing ❑ walking
6. How many minutes can you stand in one place without pain? ❑ 0-10 ❑ 15-30 ❑ 30-60 ❑ 60+
7. How many minutes can you walk without pain? ❑ 0-10 ❑ 15-30 ❑ 30-60 ❑ 60+
8. Lying down: ❑ eases the pain ❑ does not ease the pain ❑ Sometimes eases the pain
9. Bending forward: ❑ Increases the pain ❑ Decreases the pain ❑ Doesn't affect the pain

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L. For Patients with Neck or Arm Pain, numbness or weakness:

1. There is: ❑ no neck pain ❑ neck pain
2. There is: ❑ no arm pain ❑ arm pain present in the (check the following):
   Right: ❑ upper back ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
   Left: ❑ upper back ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
3. Raising the arm: ❑ improves the pain ❑ worsens the pain ❑ does not affect the pain
4. Moving the neck: ❑ improves the pain ❑ worsens the pain ❑ does not affect the pain
5. There is: ❑ no weakness of the arms and hands ❑ weakness of the (check the following):
   Right: ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
   Left: ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
6. There is: ❑ no numbness of the arms and hands ❑ numbness of the (check the following):
   Right: ❑ upper arm ❑ forearm ❑ thumb ❑ index finger ❑ long finger ❑ ring finger ❑ small finger
   Left: ❑ upper arm ❑ forearm ❑ thumb ❑ index finger ❑ long finger ❑ ring finger ❑ small finger
7. There (❑ is ❑ is no) difficulty picking up small objects like coins or buttoning buttons.
8. There (❑ is a ❑ is no) problem with balance or tripping frequently.
9. There are (❑ frequent ❑ occasional ❑ no) headaches in the back of the head.

M. All Patients please answer the following:

1. Coughing or sneezing (❑ increases ❑ sometimes increases ❑ does not increase) the pain.
2. There is: ❑ no loss of bowel or bladder control ❑ loss of bowel or bladder control since: _____
3. I have: ❑ not missed any work/school due to this problem ❑ missed (how much): _____
4. Treatments have included: ❑ no medicines, therapy, manipulations, injections or braces

Neck	Back		Neck	Back	
❑	❑	Physical therapy, exercise	❑	❑	Anti-inflammatory medications
❑	❑	Massage & ultrasound	❑	❑	Narcotic medication
❑	❑	Traction	❑	❑	Epidural steroid injections times which relieved the pain for (how long)?
❑	❑	Manipulation			
❑	❑	Tens unit	❑	❑	Trigger point injections times which relieved the pain for (how long)?
❑	❑	Shoulder injections			
❑	❑	Braces	❑	❑	Other

5. List medications and dose taken for your spine problem: ❑ none

Medication	Dose

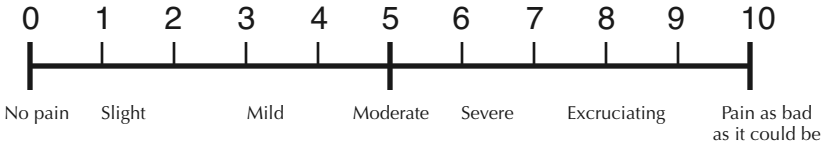
6. Previous doctors about this problem: ❑ none

Doctor	Specialty	City [if not Peoria]	Treatments

7. Tests done to evaluate your problems, the dates and location where they were done: ❑ none

test	Neck	Back	#1 Date	Where	#2 Date	Where	#3 Date	Where
Plain x-rays	❒	❒						
Myelogram	❒	❒						
CT Scan	❒	❒						
MRI	❒	❒						
EMGs	❒	❒						
Bone scan	❒	❒						

MY PAIN / DISCOMFORT IS (circle number)



Patient signature _____ date _____

Physician signature _____ date _____

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