Stony Brook Medicine

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DIVISION OF PEDIATRIC ORTHOPAEDICS
STONY BROOK ORTHOPAEDIC ASSOCIATES

Today's date:_____

Patient's Name:_____ Nickname:_____

Date of Birth:_____ Age:_____

Child's Physician: Requesting Physician:

_____ _____

_____ _____

_____ _____

Phone:_____Fax:_____ Phone:_____Fax:_____

What problem brings your child to the doctor today?_____

_____

Does your child have pain? Yes___ No___If yes, describe:

1 None | 2 A little bit | 3 A little bit more | 4 A lot | 5 Worst

Date and Mechanism of Injury:_____

BIRTH HISTORY: Were there any problems during, "mom's," pregnancy and delivery:

weeks gestation_____ Birth weight:_____

Yes___ No___ Breech position Age of walking independently:_____

Yes___ No___ Cesarean delivery. . . . . Reason for Cesarean delivery: _____

Yes ___ No ___Premature labor/delivery _____

Yes ___ No ___Diabetes

Yes ___ No ___Eclampsia/high blood pressure

Yes ___ No ___Drug or alcohol use

PAST MEDICAL/SURGICAL HISTORY

Has your child ever been hospitalized?

Yes ___ No ___If yes, for what reason:_____

_____

Has your child ever had any operations?

Yes ___ No ___If yes, what type?_____

_____

Does your child take any medications?

Yes ___ No ___If so, what kind and for what reason?_____

_____

Is your child allergic to any medications?

Yes ___ No ___ If so, what type of reaction did they have?_____

_____

Is your child up to date on immunizations? Yes ___ No ___

Girls: Have menstrual periods begun? Yes ___ No ___ When?_____

Has your child had any problems with any of the following:*****

Yes ___ No ___ Allergies
Yes ___ No ___ Asthma
Yes ___ No ___ High fevers
Yes ___ No ___ Weight loss
Yes ___ No ___ Eye problems
Yes ___ No ___ Frequent colds
Yes ___ No ___ Sore throats
Yes ___ No ___ Heart disease
Yes ___ No ___ Lung disease
Yes ___ No ___ Pneumonia
Yes ___ No ___ Diarrhea
Yes ___ No ___ Digestive problems
Yes ___ No ___ Urinary tract infections
Yes ___ No ___ Muscle weakness
Yes ___ No ___ Skeletal problems
Yes ___ No ___ Skin disease
Yes ___ No ___ Seizures
Yes ___ No ___ Delayed development
Yes ___ No ___ Spasticity
Yes ___ No ___ Diabetes
Yes ___ No ___ Thyroid disease
Yes ___ No ___ Blood disorders
Yes ___ No ___ Emotional problems
Yes ___ No ___ Learning disability

*****If **"Yes"** to any of the above problems, please explain: _____
_____

Has any **FAMILY MEMBER** had:

Yes ___ No ___Childhood arthritis Relationship to your child:_____
Yes ___ No ___Foot deformity Relationship to your child:_____
Yes ___ No ___Hand deformities Relationship to your child:_____
Yes ___ No ___Hip dysplasia Relationship to your child:_____
Yes ___ No ___Scoliosis Relationship to your child:_____
Yes ___ No ___Tuberculosis Relationship to your child:_____
Yes ___ No ___Inherited genetic disease Relationship to your child:_____

Other family medical problems not listed above:_____
_____

Who lives with your child at home?_____

What grade is your child in?_____

Does your child participate in any structured athletic programs?
Yes ___ No___ If yes, please list:_____
_____

Additional information you wish to be included in your child's medical history: _____
_____
_____

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