EMORY
ORTHOPAEDICS &
SPINE CENTER

PATIENT INFORMATION SHEET
PEDIATRIC ORTHOPAEDICS

BACKGROUND

Patient Name: _____ Date: _____

Age: _____ Ht: _____ Wt: _____ □ MALE □ FEMALE

Hobbies/Sports/Exercise Activities: _____

Primary Care Physician & Address: _____

Physicians who follow your child regularly (neurologist, pulmonologist, etc.):

_____ _____

_____ _____

Pharmacy name and address/phone number: _____

REASON FOR VISIT

_____

_____

- Does your child have pain? ❑ YES ❑ NO
  - If YES, what makes the pain better? _____
  - What makes the pain worse? _____
- On a scale of 0-10, how severe is the pain? 0 1 2 3 4 5 6 7 8 9 10
  No Pain Severe Pain
- What best describes the pain? (Check all that apply)
  □ Sharp/shooting □ Achy □ Dull □ Cramping □ Burning □ Cramping
  □ Other (explain): _____
- Was there an injury? □ Yes □ No If yes, please provide the date of injury: _____
- What treatments has the child had so far? (Check all that apply)
  □ Ice □ Heat □ Brace □ Exercises □ Chiropractor
  □ Medications (please list): _____ □ Other: _____

ALLERGIES (Please list any known drug allergies)

_____

_____

_____

_____

_____

CURRENT MEDICATIONS (List name & dose of medication):

_____

_____

_____

_____

_____

SOCIAL HISTORY

Who lives with the child? _____

What grade in school is the child (if applicable)? _____

Does anyone who lives with the child smoke? _____

EMORY
ORTHOPAEDICS &
SPINE CENTER

SURGICAL HISTORY: (List any past surgeries, including the month/year of surgery)

_____ _____

_____ _____

PAST MEDICAL HISTORY: (Please choose all current and past medical conditions)

□ No medical problems
□ High blood pressure
□ Cancer
□ Heart surgery
□ Abnormal heart rhythm
□ Seizures
□ Vision/Eye Problems
□ Asthma
□ Bronchitis
□ Recurrent Ear Infections
□ Pneumonia
□ Shortness of Breath
□ Migraine Headaches
□ Diabetes
□ Cerebral Palsy
□ Recurrent Skin Rashes
□ Reflux
□ Gallbladder Disease
□ Blood in Urine
□ Swelling in Feet or Ankles
□ Kidney Problems/Stones
□ Prior Broken Bones
□ Psychiatric Problems
□ Depression
□ Rheumatoid arthritis
□ Blood clots in legs/lungs
□ Other: _____

FAMILY HISTORY: (Indicate conditions that run in the child's close family)

Condition	*Relationship*	*Condition*	*Relationship*
□ Clubfoot	_____	□ Osteogenesis Imperfecta	_____
□ Scoliosis	_____	□ Ehlers Danlos Syndrome	_____
□ Marfan's Syndrome	_____	□ Blood Clots	_____
□ Bleeding Disorders	_____	□ Hip dislocation as a child	_____
□ Other:	_____		

REVIEW OF SYSTEMS: (Has the child experienced any of the following *recently*)

General
□ Unexplained weight loss
□ Appetite change
□ Fevers or chills
□ Night sweats
□ Marked fatigue
□ Difficulty sleeping

Ear, Eyes, Nose, Throat
□ Difficulty swallowing
□ Hoarseness
□ Loss of hearing
□ Ear pain
□ Nosebleeds
□ Gum trouble
□ Change of vision

Cardiovascular
□ Heart or chest pain
□ Abnormal heartbeat
□ Poor heart function

Digestive
□ Nausea or vomiting
□ Stomach pain or ulcers
□ Heartburn/acid
□ Frequent diarrhea
□ Frequent constipation
□ Uncontrolled loss of stool
□ Blood in stool
□ Hemorrhoids

Skin
□ Rashes
□ Frequent itchiness
□ Easy bruising
□ Swollen ankles

Neurological
□ Seizures
□ Blackouts/fainting
□ Tremors
□ Headaches/migraines

Psychiatric
□ Depression
□ Nervous exhaustion
□ Anxiety
□ Paranoia
□ Obsessive/compulsive behavior

Genitourinary
□ Burning on urination
□ Difficulty starting urination
□ Incontinence
□ Pelvic pain
□ Urinate at night more than once

Lung
□ Cough
□ Shortness of breath
□ Productive cough or sputum