

PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.
HISTORY FORM – NEW PATIENT PEDIATRIC

Chief Complaint: _____ Date of Injury: _____

W: _____ lbs H: _____ Age: _____

Pediatrician: _____ Referring Physician: _____

FIELDS MARKED WITH AN ASTERISK (*) ARE FEDERAL REQUIREMENTS.

DOB*: _____ Sex*: Male Female Smoking*: Smoker Nonsmoker Former Smoker

Current Medications, Vitamins & Supplements*

No Medications

Pharmacy | Location: _____

Allergies (please list other drug allergies)*

None Known Codeine Iodine Sulfa Aspirin Penicillin Demerol Adhesive/Tape

Other: _____

Are your injuries related to:

Auto accident Work accident School Athletic accident Other accident None

Attorney: No Yes (name, phone, address): _____

Check off any diseases with which you were previously diagnosed

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GI Reflux | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Ulcers |

Right Handed Left Handed

Orthopedic Surgeries (please include side and year)

Arthroscopy: Side: R L Body Part: _____

Spine: _____

Replacement: Side: R L Body Part: _____

Other: _____

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Other Surgeries

Fractures

What is the nature of the Patient's primary problem?

- | | | | |
|---------------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Infectious | <input type="checkbox"/> Developmental | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Neuromuscular |
| <input type="checkbox"/> Other: _____ | | | |

What part of the patient's body is involved? _____

Please describe what happened: _____

Have you had a problem before? If so, when? _____

Has anyone related to you had this problem before? If so, who? _____

What is your primary concern?

- Pain Deformity Appearance Future Problem Other: _____

Are you a CMS (Children's Medical Service) patient?

- No
 Yes: West Palm Beach Ft. Pierce

Previous diagnostic studies done for the problem?

- | | | |
|-------------------------------------|----------------------|--------------|
| <input type="checkbox"/> X-Rays | Date: ____/____/____ | Where: _____ |
| <input type="checkbox"/> Cat Scan | Date: ____/____/____ | Where: _____ |
| <input type="checkbox"/> MRI | Date: ____/____/____ | Where: _____ |
| <input type="checkbox"/> Ultrasound | Date: ____/____/____ | Where: _____ |
| <input type="checkbox"/> Bone Scan | Date: ____/____/____ | Where: _____ |
| <input type="checkbox"/> EMG/NCS | Date: ____/____/____ | Where: _____ |

Please provide past medical history:

Medical problems: _____

Problems related to birth: _____
