PEDIATRIC

PLEASE FILL OUT THE FOLLOWING AS IT WILL EXPEDITE YOUR CHILD'S INTAKE PROCESS.

THANK YOU!

ORTHOPAEDIC SURGERY SPECIALISTS, LTD.

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Notes:

Patient Name: _____

Date of Birth: _____

YOUR CHILD'S PAST MEDICAL HISTORY

Please indicate if your child has/had any of the following:

- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Back Pain
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetic Foot Ulcers
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ GI Bleed
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Irregular Heart Beat
- ☐ Kidney Failure
- ☐ Liver Problems
- ☐ Lupus
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Numbness/Tingling
- ☐ Poor Circulation
- ☐ Pulmonary Embolism
- ☐ Psoriasis
- ☐ Reflux
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Ulcers
- ☐ Urinary Tract Infection (Chronic)
- ☐ Pregnant
- ☐ **Other**

YOUR CHILD'S PAST SURGICAL HISTORY

Please indicate if your child had any of the following surgeries and specify the date (Month and Year):

- ☐ **No Surgical History**
- ☐ Abdominal Surgery-Type _____
- ☐ Amputation _____
- ☐ AV Fistula Creation _____
- ☐ AV Graft _____
- ☐ Aortic Valve Replacement _____
- ☐ Appendectomy _____
- ☐ BAF By-Pass _____
- ☐ Back Surgery _____
- ☐ Breast Surgery _____
- ☐ Bronchoscopy _____
- ☐ CABG _____
- ☐ Carotid Endarterectomy _____
- ☐ Carpal Tunnel _____
- ☐ Cataract Extraction _____
- ☐ Cholecystectomy _____
- ☐ Colon Resection _____
- ☐ Craniotomy _____
- ☐ Gastric Bypass _____
- ☐ Hemorrhoidectomy _____
- ☐ Implants Interventional Pain Procedure _____
- ☐ Knee Arthroscopy _____
- ☐ Kyphoplasty _____
- ☐ LA-F Bypass _____
- ☐ Lumpectomy _____
- ☐ Mastectomy _____
- ☐ Pacemaker _____
- ☐ Parathyroidectomy _____
- ☐ Pneumonectomy _____
- ☐ PTCA _____
- ☐ RAF Bypass _____
- ☐ Rotator Cuff Repair _____
- ☐ TAH/BSO _____
- ☐ TAH _____
- ☐ Tonsillectomy _____
- ☐ Tunneled Dialysis Catheter _____
- ☐ UPPP _____
- ☐ Urinary Incontinence Surgery _____
- ☐ Verterbroplasty _____
- ☐ Other _____

_____

Complications:

- ☐ Anesthesia Problems
- ☐ Surgical Complications
- ☐ Post-Op Delirium

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YOUR CHILD'S FAMILY MEDICAL HISTORY

Please indicate if your child's Father, Mother, Brother(s) or Sister(s) have had any of the following and note the relation:

- ☐ **FH Unremarkable**
- ☐ FH Anesthetic Complications _____
- ☐ FH Bleeding Disease _____
- ☐ FH Cancer _____
- ☐ FH Coronary Heart Disease Male <55 _____
- ☐ FH Coronary Heart Disease Female <65 _____
- ☐ FH Diabetes _____
- ☐ FH Osteoporosis _____
- ☐ FH Rheumatoid Arthritis _____

YOUR CHILD'S SOCIAL HISTORY (All questions may not apply to your child)

Is your child employed? **YES** **NO**

If so, what type of work does your child do? _____

Does your child smoke? **YES** **NO**

If so, how many packs per day? _____

Is your child exposed to second hand smoke? **YES** **NO**

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YOUR CHILD'S SYMPTOMS

Please indicate any symptoms that apply to your child.

General:
- ☐ Fevers
- ☐ Night Sweats
- ☐ Chills
- ☐ Recent weight change

Eyes:
- ☐ Disease or Injury
- ☐ Changes in vision

Ears, Nose & Throat:
- ☐ Change in Hearing
- ☐ Frequent Sneezing
- ☐ Nosebleeds

Cardiovascular:
- ☐ Chest pain or palpitations
- ☐ Shortness of breath while walking
- ☐ Difficulty in walking two blocks
- ☐ Swelling of the hands or feet
- ☐ Heart murmur

Respiratory:
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

Gastrointestinal:
- ☐ Peptic Ulcers
- ☐ Bleeding with bowel movements
- ☐ Black stools
- ☐ Recent change in bowel habits
- ☐ Frequent diarrhea
- ☐ Heartburn or indigestion

Genitourinary:
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Kidney stones

Musculoskeletal:
- ☐ Joint swelling
- ☐ Joint Pain
- ☐ Injury of joint
- ☐ Fracture

Skin:
- ☐ Hives
- ☐ Eczema
- ☐ Rash
- ☐ Abnormal pigmentation

Neurologic:
- ☐ Fainting Spells
- ☐ Convulsions
- ☐ Paralysis
- ☐ Headaches

Psychiatric:
- ☐ Depression
- ☐ Change in vision
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Weight problems

Endocrine:
- ☐ Excessive thirst
- ☐ Urinate Frequently
- ☐ Intolerance to heat/cold

Heme/Lymphatic:
- ☐ Anemia
- ☐ Difficulty with excessive bleeding
- ☐ Abnormal bruising or bleeding
- ☐ Swollen glands

Allergic/Immunologic:
- ☐ Itchy Eyes
- ☐ Runny Nose

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Please list all of your medications that you are currently taking including all vitamins and herbs/supplements. Please include the dosage and instructions for each medication that you are taking. For example: Aspirin 325 mg, 1 tablet daily.

Please list any allergies to medications or products/solutions (i.e. tape, latex) that you may have. Please list what type of reaction that you get to each medication or product that you are allergic to. For example: penicillin- hives

POS® Reorder # 1305792