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# Welcome to Mount Sinai Pediatric Orthopaedics.

**Please complete and return the following form to reception prior to seeing the doctor.**

**Patient Name: _____ Today's Date: _____**
**Patient's Date of Birth: ___/___/___ Age:_____ Height:_____ Weight:_____**

Referring MD: _____
Address: _____ City: _____ State:____ Zip:_____
Phone: _____ Fax: _____

Pediatrician: _____
Address: _____ City: _____ State:____ Zip:_____
Phone: _____ Fax: _____

**Your Child's Current Problem:**

Please describe the reason for your visit? (please include body part/side of injury/chronic vs. new)
_____
Describe the symptoms and area affected (type of pain, swelling, numbness, etc.) _____
_____
Is the patient taking any pain medication? (name, dose and frequency)_____
When did this problem begin (date of injury)? _____
If you had an injury, how did it happen? _____
Is there an attorney involved with your case? _____

**Past Medical History:**

Does the patient have any medical problems that require treatment/medication? (please list)
_____
Has the patient ever been hospitalized? _____
If patient is greater than 3 years old: What hand does the patient use to draw?_____

**Pregnancy/Birth History:**

_____ Week Pregnancy Birth Weight _____lbs. _____oz.
Presentation (circle one): Head First Breech
Complications: Prenatal: _____ After Birth: _____

**Developmental History:**

List any speech, cognitive or motor development delays: _____
Approximate age of first: Sitting _____ Walking _____

**Past Surgical History:** Please list any operations the patient has had in their lifetime.

| Year | Type of Operation |
|---|---|
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| | |

**Medications:** Please list any and all medications in as much detail as possible.

| Current Medication | Dose | Frequency | Current Medication | Dose | Frequency |
|---|---|---|---|---|---|
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**Allergies:** ☐NO ☐YES (Please list allergy and reaction) _____

**Family History:**

Family history of similar problem? If yes, please explain: _____
Parent's Age and Health Problems: Mother:_____ Father:_____
Sibling's Ages and Health Problems: _____
Does the patient or any family member(s) have any problems with anaesthesia? (please list)
_____

**Social History:**

Who lives at home with the patient? _____
Who has legal custody of the patient? _____
Does anyone in the household use tobacco? ☐NO ☐YES Whom:_____ #cigarettes/day___
Current School: _____ Current Grade: _____
Organized Sports: _____ Recreational Sports _____

**Review of Symptoms (please check all symptoms that apply):**

General:
- ☐ Unexplained Weight Loss
- ☐ Malaise
- ☐ Anaesthetic Complications

Eyes:
- ☐ Blindness
- ☐ Double vision
- ☐ Blurring
- ☐ Injury
- ☐ Glasses/Contact Lenses

Ears/Nose/Throat/Mouth:
- ☐ Deafness
- ☐ Sinusitis
- ☐ Ringing In Ears
- ☐ Hoarseness
- ☐ Dizziness

Cardiovascular:
- ☐ Chest pain
- ☐ Palpitations
- ☐ High Blood Pressure
- ☐ Heart Murmur

Respiratory:
- ☐ Shortness Of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Blood in sputum

Gastrointestinal:
- ☐ Changes in appetite
- ☐ Weight Changes
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain

Genitourinary:
- ☐ Urinary Incontinence
- ☐ Pain with Urination
- ☐ Frequency in Urination
- ☐ Menstrual Problems
- ☐ Pregnancies

Musculoskeletal:
- ☐ Fractures: (List locations)

_____

- ☐ Sprains
- ☐ Pain
- ☐ Swelling
- ☐ Arthritis
- ☐ Connective Tissue Disease

Skin:
- ☐ Rashes
- ☐ Scars
- ☐ Masses
- ☐ Birthmarks

Endocrine:
- ☐ Disordered Eating
- ☐ Abnormal Growth
- ☐ Hair Changes

Neurological:
- ☐ Headaches
- ☐ Numbness
- ☐ Disturbance In Sensation
- ☐ Seizures
- ☐ Visual Changes
- ☐ Auditory Changes
- ☐ Weakness
- ☐ Change in Coordination
- ☐ Memory Issues

Psych:
- ☐ Hyperactivity
- ☐ Attention Deficit Disorder
- ☐ Depression
- ☐ Hallucinations
- ☐ Sleep Disturbances
- ☐ Suicidal Thoughts

Hematologic:
- ☐ Bleeding Problems
- ☐ Anemia
- ☐ Swollen Lymph Nodes
- ☐ Leukemia

Allergic:
- ☐ Dermatitis
- ☐ Eczema
- ☐ Seasonal Allergies
- ☐ Food Allergies
- ☐ Latex Allergies



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FOR OFFICE USE ONLY:

I have personally reviewed and verified the above historical elements and have performed a physical exam. Signature: _____ Date: _____