St. Luke's Clinic – Pediatric Orthopedics

Patient Name :	**Date:**
Father's Name:	Mother's Name:
Patient's Primary Physician	
Referring Physician (if different than above)	

DOB:	**Age:**	**Sex:**	**Height:**	**Weight:**

REASON FOR VISIT:	**Body Part affected:**
Date of onset: _____ / _____ / _____	**Other MD's involved:**
Result of Injury: ☐ **Yes** ☐ **No**	**Litigation Pending:** ☐ **Yes** ☐ **No**

If Injury, describe:

☐ **Work Related** ☐ **Auto Accident** ☐ **Sports Injury** ☐ **Other Accident**

Since you first noticed the problem, is it: ☐ **BETTER** ☐ **WORSE** ☐ **SAME**

There is family history of the problem	☐ No	☐ Yes ____________________
There is pain associated with the problem	☐ No	☐ Yes ____________________
There is a history of trauma/accidents involving the painful area	☐ No	☐ Yes ____________________
There is a history of broken bones or fractures	☐ No	☐ Yes ____________________
This problem has been previously treated	☐ No	☐ Yes ____________________
The patient's immunizations are current	☐ No	☐ Yes ____________________

ALLERGIES: **Reaction:**

CURRENT MEDICATIONS

Name	Dose	Reason	Name	Dose	Reason
1)			3)		
2)			4)		

MAJOR ILLNESSES/HOSPITALIZATIONS/SURGERIES

1)	2)
3)	4)

FAMILY/BIRTH/DEVELOPMENT HISTORY

Dependent lives with:

☐ Father & Mother ☐ Mother Only ☐ Father Only ☐ Grandparents
☐ Mother - Remarried ☐ Father - Remarried ☐ Legal Guardian ☐ Other ____________

Patient was born at ______________________________ hospital.
☐ Early ☐ Late (By how many weeks? _______) ☐ Full Term

Birth Weight _________	**Birth Height __________**	**Days in hospital after delivery __________**

Delivery Position: ☐ Breech ☐ Head First	**Type of Delivery:** ☐ Vaginal Delivery ☐ C-Section
Child sat up at _______ months	Child crawled at _______ months
Child walked at _______ months	Child spoke at _______ months

☐ Child can walk up stairs	☐ Child can hop	☐ Child can skip

REVIEW OF SYSTEMS

Within the last week, has the patient experienced any of the following: (Mark all that apply)

Cardiovascular	GI/GU	General
☐ Anemia/Blood deficiency	☐ Incontinence	☐ Fevers
☐ Nose Bleed	☐ Nausea / Vomiting	☐ Chills
☐ Blood Clots	☐ GI Bleed	☐ Fatigue
	☐ Difficulty Urinating	☐ Recent Weight Changes
Skin	☐ Urinary Tract Infection	☐ Hormone Therapy
☐ Wound Health Problems	**Head/Eye/Ears/Nose/Throat**	☐ Night Sweats
☐ Ulceration/Breakdown	☐ Frequent Headaches	☐ Psychiatric Disorders
☐ Cold Sensitivity	**Pulmonary**	☐ Steroid Use (oral or injected)
☐ Rash	☐ Asthma or wheezing	
	☐ Pneumonia or bronchitis	
	Musculoskeletal	
	☐ Pain with walking	☐ Pain walking stairs
	☐ Back Pain	☐ Muscle/Joint Weakness

Learning Assessment

Do you have any barriers to learning? (Check all that apply)

☐ **Reading** ☐ **Language** ☐ **Visual** ☐ **Hearing** ☐ **Physical**

☐ **Emotional** ☐ **Cognitive** ☐ **Financial** ☐ **Spiritual** ☐ **Cultural**

☐ **Other:** ______________________________________

How do you prefer to learn new concepts?
(Check all that apply)

☐ **Listening** ☐ **Reading** ☐ **Demonstration** ☐ **Pictures / Video**

Primary Language Spoken:

Is an interpreter required for your appointments?

☐ **No**
☐ **Yes**

Physician's Notes

Who completed this form?: ____

Signature: ____ **Date:** ______________