TTUHSC School of Medicine Children's Orthopaedic Center Lubbock, Texas Patient INTAKE/ADMISSION Form Page 1 of 2	**Patient Name:** ______________________________ **Medical Record Number:** ______________________ **Date of Birth:** __________________ **Age:** __________

Demographic Information

Person completing form: ______________________________ Relation to patient: ______________

Patient's address: __________________________________ Phone #1: ____________________

City/State/Zip: ____________________________________ Phone #2: ____________________

Primary Language: ______________

Requesting Physician Information

Requesting Physician Name: ___________________________ Phone: ______________________

Pediatrician/Primary Care Physician: _____________________ Phone: ______________________

Reason for Visit

Did your child sustain an injury? YES___ NO___ Date of Injury: ___________________________

What was injured? ____

If your child was not injured, please describe what problems your child is having: ____________________

____

How long has he/she had this problem? ____

What makes it better? __________________________ What makes it worse? ________________

Describe the type of pain that your child has: ____

Review of Systems

Please check any of the following <u>your child</u> has had recently:

____Fever/chills ____Feet turning in/out ____Extremity weakness ____Nausea/vomiting

____Joint pain ____Muscle pain ____Trouble walking ____Bowed legs

____Joint swelling ____Easy bruising ____Numbness/tingling ____Knock-knees

Child's Past Medical History

Current height: ________ feet ________ inches Current weight: _______________ pounds

Current medications <u>your child</u> is taking: ____

____

ALLERGIES TO MEDICATIONS: ____ Yes ____ No If yes, name of medication(s): __________________

____

Please check any of the following <u>your child</u> has had:

____Heart problems ____Bleeding problems ____Large/unusual/multiple birthmarks

____Asthma ____Brittle bone disease ____Irregular heartbeat ____Hiatal hernia

____Diabetes ____Kidney problems ____Juvenile rheumatoid arthritis ____Inguinal hernia

____Seizures ____Stroke ____Gastro-esophageal reflux ____HIV/AIDS

Please describe any other medical problems <u>your child</u> has: ___________________________________

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TTUHSC School of Medicine Children's Orthopaedic Center Lubbock, Texas Patient INTAKE/ADMISSION Form Page 2 of 2	**Patient Name:** ____ **Medical Record Number:** ____________________________ **Date of Birth:** _____________________ **Age:** ___________

Please describe any surgeries (and when) your child has had: ____
____
____

Birth History

Was your baby born _____Early _____On Time _____Late? Length of Pregnancy (weeks): ____________weeks
How much did your baby weigh at birth? _______ pounds ______ ounces
How was your baby delivered? _____Vaginal OR _____C-Section _____Feet First (Breech) OR _____Head First
Were there any complications during delivery or immediately after birth? _____ Yes _____ No
If yes, please describe: ____
____
Did your child stay in the NICU? ____Yes ____No If yes, how long was he/she there? _____________________

Child's Developmental History

At what age did your child: Sit alone without support __________________
Pull self to standing position ________________
Walk without help ________________________
Does your child require: ____ Crutches _____ Braces _____ Wheelchair _____ No Assistive Devices
How does your child communicate? ___Verbally ____Sign Language _____Other: ________________________
Menstrual history: Has your daughter started having periods? ____Yes ____No
If yes, when was the first period? __________ Most recent period? ___________

Family/Social History

Siblings: Names and ages ____
____
What school does your child attend? ____ Grade ___________

Does your child currently receive therapy? ____Yes ____No

If yes: Speech_____ Physical _____ Occupational_____ Other____

Does your child have any specials needs? ____
Please check any of the following medical problem(s) anyone in your immediate family (mother, father, brother, sister) has had:

_____Scoliosis _____Flat Feet _____Dislocated Hip at Birth _____Anesthesia Problems
_____Club Feet _____High Arches _____Bowed Legs _____Multiple Fractures
_____Neuromuscular Problems _____Neurofibromatosis _____Abnormal Growth of Long Bones

Physician Statement ____
____

___________________________________ ___________________________________ _________________
Physician Signature Physician Printed Name Date