HOSPITAL FOR SPECIAL SURGERY

Office use only:
MR#___________________

Pediatric Services

☐ Dr Blanco ☐ Dr Doyle ☐ Dr Green ☐ Dr Raggio
☐ Dr Root ☐ Dr Scher ☐ Dr Widmann ☐ Other______________________

DEMOGRAPHIC INFORMATION

1. Patient Name:______________________
2. Date of Birth: (month/Day/Year)______________
3. Age:_____________________________
4. Social Security Number:______________
5. Patient Sex: ☐ Male ☐ Female
6. Address:______________________________
7. Email:________________________________

Pediatrician:

Name:___________________________________

Phone No:_______________________________

Address:_________________________________

Contact information:

Legal Guardian:

1. Name:_______________________
2. Relationship to patient:_____________
3. Date of birth:(month/Day/Year)___________
4. Social Security number:_____________
5. Home phone no:__________________
6. Work phone no:__________________
7. Mobile phone no:_________________
8. Address: ☐ Same as patient
9. Employer:_______________________

Secondary Contact (if appropriate):

1. Name:_______________________
2. Relationship to patient:_____________
3. Date of birth:(month/Day/Year)___________
4. Social Security number:_____________
5. Home phone no:__________________
6. Work phone no:__________________
7. Mobile phone no:_________________
8. Address: ☐ Same as patient
9. Employer:_______________________

Please confirm with your physician's office whether the following section is applicable to the patient:

I, the above listed patient's parent/legal guardian, authorize the following responsible adult (please print name)________________________ (relation to patient)______________________to accompany my child to medical appointments (excluding the initial evaluation and as set out below). I understand that this authorization only permits the person named above to act as my child's escort. Further, I understand that at any time, and in their sole discretion, the treating physician or Hospital for Special Surgery may require the presence of a parent/legal guardian at any specified appointments. *Signature:*______________________ *Date*______________

Insurance: **Primary Insurance:**

☐ Insurer ________________________
☐ No-Fault ☐ Medicaid
☐ Self-Pay ☐ Other ___________
Name of Insured:____________________
Insured's DOB:_____________________
Insured's Social Security #:_____________
Insurance ID #:_____________________
Insurance Group #:__________________
Insurance Company Phone# and address:

Secondary Insurance:

☐ Insurer ________________________
☐ No-Fault ☐ Medicaid
☐ Self-Pay ☐ Other ___________
Name of Insured:____________________
Insured's DOB:_____________________
Insured's Social Security #:_____________
Insurance ID #:_____________________
Insurance Group #:__________________
Insurance Company Phone# and address:

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Name:________________________
Date:________________________
DOB:________________________

HEALTH HISTORY

Please check any current or past health problems which the patient has had.

☐ ADD /ADHD
☐ Allergies
☐ Anemia
☐ Arthritis (Osteo / rheumatologic)
☐ Asthma
☐ Behavioral Issues
☐ Blood Disorders
☐ Broken Bones / Fractures
☐ Bronchitis
☐ Cancer
☐ Cerebral Palsy
☐ Chronic Ear Infection
☐ Circulation / Vascular Disorder
☐ Depression
☐ Developmental or Growth problems
☐ Diabetes / High Sugar
☐ Dysautonomia
☐ Eczema / Skin Disorders
☐ Gastric Reflux
☐ Head Injury / TBI
☐ Heart Problems
☐ Heart Murmur
☐ High blood pressure
☐ Hydrocephalus
☐ Kidney Disorder
☐ Liver Disease
☐ Low Blood Sugar (hypoglycemia)
☐ Lung Problems
☐ Lupus (SLE)
☐ Osteogenesis Imperfecta
☐ Osteopenia / Osteoporosis
☐ Pneumonia
☐ Chronic or Repeated Infections
☐ Seizures /Epilepsy
☐ Sickle cell anemia
☐ STD
☐ Stroke
☐ Thyroid Disorder
☐ Tonsillitis
☐ Ulcer / Stomach disorder
☐ Other
____
☐ None of the Above

Height:__________________________ Weight:__________________________

ALLERGIES

Please list any known allergy (latex, food, drug, etc) that the patient may have including the reaction that he/she experienced: ____
____

COMMUNICABLE DISEASES

☐ Measles
☐ Mumps
☐ Chicken Pox
☐ German Measles
☐ HIV
☐ TB
☐ STD
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

☐ None of the above

SYSTEMS REVIEW

Please check any problems that the patient has had during the last year

☐ Bowel Problems
☐ Chest Pain
☐ Coordination Problems
☐ Cough
☐ Difficulty Sleeping
☐ Difficulty Swallowing
☐ Difficulty Walking
☐ Dizziness or Blackouts
☐ Fever/Chills/Sweats
☐ Headaches
☐ Heart Palpitations
☐ Hoarseness
☐ Joint Pain OR Swelling
☐ Loss of Appetite
☐ Loss of Balance
☐ Nausea
☐ Pain at Night (If Yes location)
____
☐ Shortness of Breath
☐ Urinary Problems
☐ Vision Problems
☐ Weakness in Arms or Legs
☐ Weight Loss or gain
☐ Other ________________
____
____
☐ None of the above

MEDICAL TESTS

Please check any tests that the patient has had during the last year

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Blood Tests
☐ Bone Scan
☐ Bronchoscopy
☐ CT Scan
☐ Doppler Ultrasound
☐ Echocardiogram
☐ EEG (Electroencephalogram)
☐ EKG (Electrocardiogram)
☐ EMG (Electromyography)
☐ MRI
☐ Myelogram
☐ NCV (Nerve Conduction Velocity)
☐ PAP Smear
☐ Pulmonary Function
☐ Spinal Tap
☐ Stool Tests
☐ Urine Tests
☐ X-Rays
☐ Other
____
☐ None

MEDICATIONS

Does the patient take any prescription or non-prescription medication? Please check all that apply.

NON-PRESCRIPTION

☐ Advil™/Aleve™
☐ Antacid
☐ Antihistamines
☐ Aspirin
☐ Herbal supplements
☐ Decongestants
☐ Tylenol™
☐ Vitamins
☐ Other
____
☐ None
☐ See medication reconciliation list

PRESCRIPTION

1_________________________ 4_________________________
2_________________________ 5_________________________
3_________________________ 6_________________________

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Name:_________________________
Date:__________________________

SURGICAL HISTORY

Please list any surgical procedure that the patient has had along with the date the procedure was performed and the hospital in which it was perfromed

DATE:	PROCEDURE	HOSPITAL / DOCTOR
1.		
2.		
3.		
4.		
5.		
6.		

☐ See problem list

GENERAL HEALTH

1. Please rate the patient's general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Have you or the patient had any major life changes (such as a new baby, job change, or death of a family member) during the last year? ☐ Yes ☐ No
3. Does the patient exercise beyond normal daily activities, Gym class and chores? ☐ Yes ☐ No

If yes please describe and list all of the organized or competitive sports teams that the patient is on:______

____
____
____
____

4. Approximately how many servings of calcium rich foods does the patient eat daily?_______________
   (1 serving = 1 cup of milk/yogurt; 2 oz of processed cheese; 4 tbs parmesan cheese; 2 oz of almonds; 1 cup of cooked green leafy vegetables)
5. Is the patient lactose intolerant? ☐ Yes ☐ No
6. Does the patient smoke? ☐ Yes ☐ No: How often?________________
7. Does anyone in your household smoke? ☐ Yes ☐ No: How often?___________
8. Has the patient been exposed to or had experience with any illicit/street drugs or alcohol? ☐ Yes ☐ No:
   Please describe___________________________________

FOR GIRLS:

Age of first menses (monthly period):________________ Date of last menses (monthly period):________________

Is the patient currently pregnant, or do you think that she might be pregnant? ☐ YES ☐ NO

Sexual History

☐ Not Applicable

Is the patient sexually active? ☐ Yes ☐ No If yes type of birth control used?________________________

FUNCTIONAL LIMITATIONS

Please check all that currently apply to the patient

Does the patient have difficulty with self-care (such as bathing, dressing, eating, toileting, etc)

☐ Yes ☐ No

Does the patient have difficulty with movement? ☐ Yes ☐ No (please check all that apply)

- ☐ transfers (bed to chair, sit to stand, bed to commode, chair to commode, etc)
  - ☐ gait (walking)
    - ☐ on level surfaces
    - ☐ on stairs
    - ☐ on uneven surfaces (hills)
    - ☐ endurance/distance (please indicate how far the patient can walk)__________

Does the patient have difficulty during recreation, play or athletics? ☐ Yes ☐ No (please check all that apply)

- ☐ running
- ☐ jumping
- ☐ PE (Gym) class
- ☐ Competitive/organized sports.

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HEALTH CARE PROVIDERS

Please list any and all additional healthcare providers whose care the patient is in:

SPECIALTY	NAME / MEDICAL GROUP	PHONE NUMBER
Pediatrician		
Orthopaedist		
Cardiologist		
Pulmonologist		
Neurologist		
Gastroenterologist		
Endocrinologist		
Rheumatologist		
OB/Gynecologist		
Physical Therapist		
Occupational Therapist		
Speech Therapist		
Psychologist		

DEVELOPMENTAL MILESTONES

MILESTONE	AGE
Child rolled over at	
Child sat up unsupported at	
Child walked independently at	
Child spoke (3 word sentences) at	

Was the patient born prematurely? ☐ Yes ☐ No (weeks)__________ Child's Birth Weight:__________
Was the patient born via cesarean section? ☐ Yes ☐ No If yes why? ________________
Is the patient attending school? ☐ Yes ☐ No If not why? ________________
Does the patient receive Special Education services? ☐ Yes ☐ No
Is the patient currently in an age appropriate grade level? ☐ Yes ☐ No

CURRENT STATUS

1. **Who referred you to this office (name, address, phone number)?**________________
2. **Reason for today's visit?**________________
3. **When did this problem first start?**________________
4. **Since the problem was first noticed is it?**
   ☐ Better ☐ Worse ☐ Same Explain:________________
5. **Is there a family history of the same or similar problems?** ☐ Yes ☐ No
6. **Is there a family history of any of the following?** (check all that apply)
   ☐ Hip Dysplasia ☐ Clubfoot ☐ Blood or Blood clotting disorders ☐ Hepatitis ☐ TB
   ☐ Scoliosis or other spine disorders ☐ SCFE (slipped capital femoral epiphysis)

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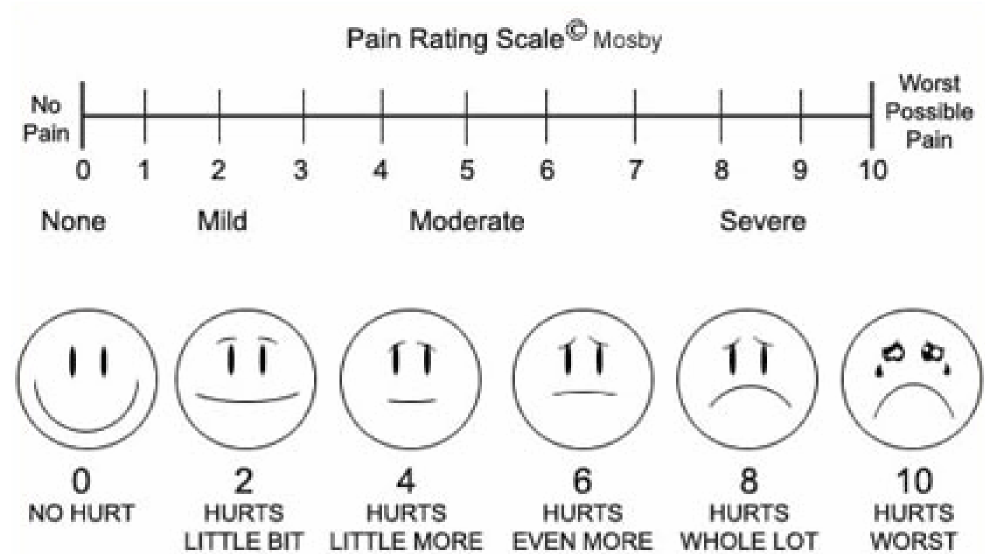
PAIN RATING

Is the patient experiencing pain? ☐ Yes ☐ No
Please describe the pain to the best of your ability____________________________________
____
____

Please rate the pain:
Circle the number and face that best describes the pain at its worst.

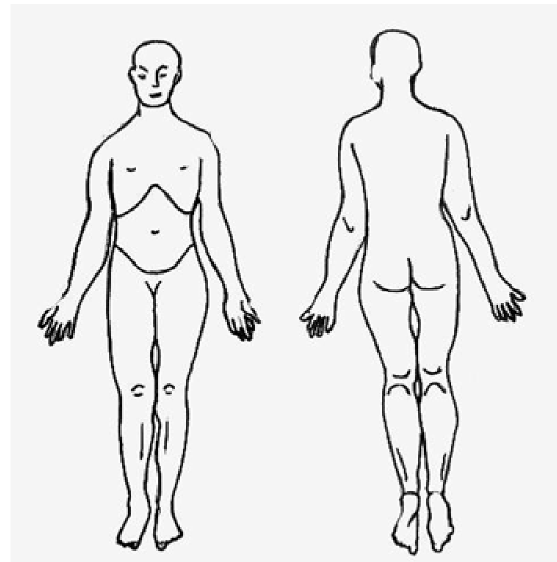


Please mark the location of the pain on the diagram below

Location: ☐ Right ☐ Left ☐ Both sides

Type: ☐ Always ☐ Sometimes
Activities that make the pain decrease:
____
____
____
____
____

Activities that make the pain increase:
____
____
____
____
____



ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT. I certify that the information provided by me is correct. I understand that this information is entered into a database, and hereby authorize the sharing of such information with the physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the physician and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.

Name of person completing this form________________________Relation to patient____________________

Patient or Guardian’s Signature____________________________________Date________________________

Reviewed by:____Date________________Time:__________