



Center for Pediatric Orthopaedic Surgery

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Medical Information

Patient's Name _____ Date of Last Visit: _____

Sex: M F Age: ____ yrs ____ mos

1. Reason for today's visit? _____

2. When did the problem first start? _____

3. Since you first noticed it, is the problem: [] Better? [] Worse? [] The same? PLEASE EXPLAIN ALL YES ANSWERS

4. Is there any pain? [] No [] Yes Location: _____

5. Has this problem been treated previously? How? [] No [] Yes By Whom? _____

6. Is there a family history of this or a similar problem? [] No [] Yes In Whom? _____

7. Past medical history: Any major illnesses? [] No [] Yes Previous operations: [] No [] Yes Current Medications; [] No [] Yes Allergies to medications? [] No [] Yes

8. Patient's birth history: For mother: # of pregnancies # of children # of this child Birth place (Hospital) (City) Birth weight lbs oz Premature Problems? Breech position? Caesarian section? # weeks gestation If yes, give reasons

9. Developmental history: Child sat up at: Child walked at: Child spoke at:

10. Review of systems: Any problems with: Heart system Lung system Neurologic system Urologic system Skin Gastrointestinal system Immune system

Signature of person completing this form Relationship to patient