34474-08

Children's Healthcare of Atlanta
Children's Physician Group - Orthopaedics

PATIENT INFORMATION FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Patient Last Name: _____ First Name: _____ Date of Birth: _____
Primary doctor: _____ Referring doctor:_____

Social History
Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Siblings ☐ Other
Number of brothers 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other_____
Number of sisters 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other_____
Is the patient adopted? Yes ☐ No ☐
If the patient is 13 or older: Do you drink alcohol? Yes ☐ No ☐
Do you use tobacco? Yes ☐ No ☐

Medications:
I am not taking any medications ☐

Name of medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		

Family History
Please indicate if your family has a history of the following: (Only include parents, grandparents, siblings and children)
Family history unknown ☐
Neurologic disease ☐ Scoliosis ☐ Bone cancer ☐ Hip dysplasia ☐ Clubfoot ☐
Short stature ☐ Heart disease ☐ Benign Bone Tumors ☐ Rheumatoid arthritis ☐

Developmental history
Was the pregnancy full-term? Yes ☐ No ☐ If no, what was the length of the pregnancy in weeks? _____
Was your child breech? Yes ☐ No ☐
Type of delivery: Vaginal ☐ C-section ☐
Birth weight:_____
Were there any problems during the pregnancy? Yes ☐ No ☐ If yes, please explain_____
Length of hospital stay after birth (days):_____
Is the patient able to sit? Yes ☐ No ☐ If yes, age when first sitting:_____
Is the patient able to walk? Yes ☐ No ☐ If yes, age when first walking:_____
If female, has the patient started menses? Yes ☐ No ☐ If yes, age at menarche:_____

Allergies
Do you have any allergies to the following medications or items?
No allergies ☐ Penicillins ☐ Cephalosporins ☐ Sulfa ☐ Mycins ☐ Latex ☐ Dye ☐ Food ☐ Other ☐
What was the reaction you experienced?_____

Past Surgical History Please indicate if the patient has had the following surgeries (write date of surgery on the line)

1) Baclofen pump _____
2) Clubfoot _____
3) Cochlear implant _____
4) Ear Tubes (BMT) _____
5) Eye surgery _____
6) Fracture repair _____
7) Fundoplication _____
8) G-tube _____
9) Heart Surgery _____
10) Hernia repair _____
11) Kidney/bladder/urinary surgery _____
12) Tonsillectomy/adenoidectomy (T&A) _____
13) Tracheostomy _____
14) Vagal nerve stimulator _____
15) VP shunt _____
16) Other _____

34474-08

Children's Healthcare of Atlanta
Children's Physician Group - Orthopaedics

PATIENT INFORMATION FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Past Medical History Please indicate if the patient has a history of the following:

1) Anemia ☐
2) Asthma ☐
3) ADD/ADHD ☐
4) Bleeding problems (hemophilia) ☐
5) Blood clots ☐
6) Cancer ☐
7) Cerebral palsy ☐
8) Charcot Marie Tooth ☐
9) Clubfoot ☐
10) Deep Vein Thrombosis ☐
11) Developmental delay ☐
12) Developmental Dysplasia Hip ☐
13) Diabetes ☐
14) Down syndrome ☐
15) Elevated Cholesterol ☐
16) Gastritis ☐
17) GI reflux ☐
18) Heart disease ☐
19) Head injury/Concussion ☐
20) High blood pressure ☐
21) Hydrocephalus ☐
22) Irregular Heartbeat ☐
23) Kidney problems ☐
24) MRSA infection ☐
25) Muscular dystrophy ☐
26) Myopathy ☐
27) Neurofibromatosis ☐
28) Osteochondromas ☐
29) Osteogenesis imperfecta ☐
30) Perthes disease ☐
31) Seizures ☐
32) Sickle cell trait/disease ☐
33) Scoliosis ☐
34) Slipped capital femoral epiphysis ☐
35) Spina bifida ☐
36) Ulcer Disease ☐
37) Urinary tract disease ☐
38) Other_____ ☐

Family History Please check all that apply to your extended and immediate family history conditions

1) Blood clots ☐
2) Diabetes ☐
3) Hypertension ☐
4) Rheumatoid Arthritis ☐
5) Anesthetic Problems ☐
6) Cancer ☐
7) Heart Disease ☐
8) Osteoporosis/Arthritis ☐
9) Stroke ☐
10) Benign Bone Tumors ☐
11) Neurologic Disease ☐
12) Scoliosis ☐
13) Bone Cancer ☐
14) Hip Dysplasia ☐
15) Seizures ☐
16) Sudden Death ☐
17) Marfan's Syndrome ☐
18) Long QT Syndrome ☐
19) Other_____ ☐

Review of systems

FIRST VISIT: Mark all symptoms that pertain to the patient
REPEAT VISIT: Only mark the symptoms that the patient has experienced since the last visit
IF NO SYMPTOMS: Mark "None"

General:
1) Fever ☐
2) Fatigue ☐
3) Weight loss ☐
4) Weight gain ☐
5) Persistent infections ☐
6) Fainting ☐
7) Dizzy spells ☐

Neurologic:
1) Fainting ☐
2) Numbness/Tingling in fingers or toes ☐
3) Seizures ☐
4) Trouble walking ☐
5) Headaches ☐
6) Head trauma ☐
7) ADD/learning issues at school ☐

Eyes:
1) Visual disturbances ☐
2) Glasses/contacts ☐
3) Discharge ☐

Genitourinary:
1) Kidney/bladder infection ☐
2) Pain with urination ☐
3) Inability to control urine ☐

Ear, Nose and Throat:
1) Hearing loss ☐
2) Congestion ☐
3) Seasonal allergies ☐
4) Discharge ☐
5) Recurrent infection ☐

Gastrointestinal:
1) Nausea ☐
2) Vomiting ☐
3) Constipation ☐
4) Diarrhea ☐
5) Feeding Problems ☐
6) Change in bowel habits ☐

Respiratory:
1) Chest Pain ☐
2) Difficulty Breathing ☐
3) Chronic Cough ☐
4) Wheezing ☐

Endocrine:
1) Hair changes ☐
2) Heat tolerance ☐
3) Cold tolerance ☐
4) Short stature/growth delay ☐
5) Thyroid problems ☐
6) Problems with growth hormone ☐

Cardiovascular:
1) Chest Pain ☐
2) Palpitations ☐
3) Difficulty breathing on exertion ☐
4) Shortness of Breath ☐

Musculoskeletal:
1) Joint Pain ☐
2) Joint Swelling ☐
3) Muscle Pain ☐
4) Muscle Weakness ☐
5) Fractures ☐

Skin:
1) Dry Skin ☐
2) Rash ☐
3) Change in Wart/Mole ☐
4) Skin Ulcer ☐
5) Eczema ☐
6) Itching ☐
7) Large Birth Mark ☐

Psychiatric:
1) Anxiety ☐
2) Frequent Crying ☐
3) Depression ☐
4) Addiction ☐
5) Behavioral Problems ☐

Heme/Lymphatic:
1) Easy Bruising ☐
2) Excessive Bleeding ☐
3) Gland Problems ☐
4) Frequent Nose Bleed ☐
5) Low Blood Counts ☐

NONE of the Above ☐

Parent/Guardian Signature:_____ Date:_____ Time:_____

34474-08

Children's Healthcare of Atlanta
Children's Physician Group - Orthopaedics

PATIENT INFORMATION FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

For in-clinic use only

Temp	HR	RR	B/P	Wt (kg)	Ht (cm)	HC	O2 Sat

Pain Score	Pain Scale

Staff Signature: _____ Date:_____ Time:_____