New Patient Questionnaire

Pediatric Orthopaedic Surgery

HOSPITAL FOR SPECIAL SURGERY

First Name:	Middle:
Last Name:	DOB:

Height:	Weight:

Primary Care Physician/Pediatrician

Name: _____

Address: _____ Phone Number: _____

Chief Compliant

What is the reason for your visit? _____

_____

When did this condition start? _____

Please explain how this condition started: _____

Since the problem was first noticed, is it: ◯ Better ◯ Worse ◯ Same

Current Pain Level (no pain 0 – 10 highest):

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		

Dietary or Herbal Supplements		
Name	Dose	Frequency
1.		
2.		

Allergy	Reaction
1.	
2.	
3.	

Name:

Medical History ☐ *Please check box if Medical History is Negative (None Apply)*

Cardiovascular	Pulmonary	Musculoskeletal	Neurological
Circulation-Vascular Disorder	Asthma	Arthritis	Cerebral Palsy
Heart Murmur	Chronic Bronchitis	Fractures	Developmental Delay
Heart Problems	Pneumonia	Osteogenesis Imperfecta	Dysautonomia
Hypertension			Head Injury
			Hydrocephalus
			Seizures
			Stroke

Gastrointestinal	Renal	HEENT	Endocrine
Failure to Thrive	Kidney Disease	Chronic Ear Infection	Diabetes Mellitus
GERD		Sleep Apnea-obstructive	Hypoglycemia
Liver Disease		Tonsillitis	Osteoporosis
Ulcers (GI)			Thyroid Disease
			Growth Hormone

Hematology	Oncology	Immunological	Rheumatic Diseases
Anemia	Cancer	Allergies	Juvenile Idiopathic Arthritis
Anesthesia Complications		Chronic/Repeated Infection	Kawasaki Disease
Blood Disorders			Lupus
Sickle Cell Anemia			Lyme Disease
			Rheumatoid Arthritis
			Scleroderma
			Sjogren's Syndrome
			Uveitis

Skin	Psychiatric	Communicable Disease
Eczema	ADD/ADHD	Hepatitis A
	Autism	Hepatitis B
	Behavioral Disorders	Hepatitis C
	Depression	HIV/AIDS
		Measles
		MRSA Infection
		Mumps
		Rubella
		Tuberculosis
		Varicella

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Do you or a family member have a history of complications with anesthesia? ◯ Yes No ◯

Name:

Social History

Who does the patient live with?_____

(Please complete this section if over the age of 10)

Are you a tobacco user? ◯ Yes ◯ No

Do you use electronic nicotine delivery systems (e-cigarettes, vape-pens, etc.)? ◯ Yes ◯ No

Do you consume alcohol? ◯ Yes ◯ No

Do you use drugs? ◯ Yes ◯ No

Are you sexually active? ◯ Yes ◯ No

Female Patients Only

Date (month and year) and Age of first menses: _____

Date of last menses (monthly period): _____

Are you currently pregnant, or do you think that you might be pregnant? ◯ Yes ◯ No

Family History

Are there any illnesses that run in the family (mother, father, brother, sister)?

Arthritis	◯ Yes	◯ No	Relation: _____
Asthma	◯ Yes	◯ No	Relation: _____
Birth Defects	◯ Yes	◯ No	Relation: _____
Clotting Disorder	◯ Yes	◯ No	Relation: _____
Clubfoot	◯ Yes	◯ No	Relation: _____
Bleeding Disorder	◯ Yes	◯ No	Relation: _____
Hip Dysplasia	◯ Yes	◯ No	Relation: _____
Learning Disability	◯ Yes	◯ No	Relation: _____
Rheumatoid Arthritis	◯ Yes	◯ No	Relation: _____
SCFE	◯ Yes	◯ No	Relation: _____
Scoliosis	◯ Yes	◯ No	Relation: _____
Spine Disorder	◯ Yes	◯ No	Relation: _____
Other: _____			Relation: _____

Please list any and all additional healthcare providers:

Specialty	Name/Medical Group	Phone Number
1. Orthopedist		
2. Pulmonologist		
3. Neurologist		
4. Cardiologist		
5. Endocrinologist		
6. Hematologist		
7. Neurosurgeon		
8. Rheumatologist		
9. Physiatrist		
10. Physical Therapist		
11. Speech Therapist		
12. Psychologist		
13. Other:		

Review of Systems ☐ *Please check box if entire Review of Systems is Negative (None Apply)*

Constitutional	Hematologic	Respiratory	Skin
Chills	Easy bruising/bleeding	Shortness of breath	Hives
Fever	Clotting disorder	Cough	Rash
Sleep disturbance	Nose bleeding	Wheezes	Infections
Fatigue	Gum bleeding	Upper resp. infection	
Night sweats			
Night pain			

ENT	Cardiovascular	Endocrine	Musculoskeletal
Vision problems	Chest pain	Weight loss	Joint pain
Hoarseness	Palpitations	Weight gain	Joint swelling
Snoring	Poor circulation		Leg weakness
			Arm weakness
			Back pain

Gastrointestinal	Genitourinary	Neurological	Psychiatric
Bowel problems	Urinary problems	Coordination problems	Anxiety
Trouble swallowing		Dizziness	Mood swings
Loss of appetite		Blackouts	Depression
Nausea		Loss of balance	
Vomiting		Difficulty walking	
Diarrhea		Headaches	

Eyes	Environmental Allergies	Other
Dryness	Pollen	
Discharge	Dust Mites	
Itching	Pets/Animals	
Pain	Mold/Mildew	
Redness		

Please complete the Birth History and Developmental History sections only if child is < age 6, or if relevant to current orthopaedic problem.

Birth History and Development

Was the patient born prematurely? ◯ Yes ◯ No

If yes, please specify the number of weeks the child was born: _____

Indicate the patient's birth weight: _____

Delivery Method:

Vaginal	Spontaneous	Breech	Forceps	Vacuum (extractor)
C-Section	Classical	Unspecified		

If child was born via C-Section, please indicate reason: _____

Currently attending school? ◯ Yes ◯ No

Receiving special education services? ◯ Yes ◯ No

Enrolled in age appropriate grade level? ◯ Yes ◯ No

Current grade level: _____

Developmental Milestones/History

Developmental History (please select):

◯ Development is Normal	◯ Mild Developmental Delays
◯ Global Developmental Delays	◯ Unknown

Child first walked independently: _____

Child first rolled over: _____

Child first spoke 3 words: _____

Child first sat unsupported: _____

Educational grade level: _____

Reviewed by:

Nurse: _____ Date: _____

Physician: _____ Date: _____