Missouri
Orthopaedic Institute
University of Missouri Health Care
1100 Virginia Avenue
Columbia, MO 65212

MRN: _____

NEW PATIENT PEDIATRIC ORTHOPAEDIC INFORMATION

Today's Date ____ / ____ / ____

Name _____

Date of Birth ____ / ____ / ____

Pediatrician or Primary Physician: _____

Physician's Address: _____
(for us to send records)

_____

Who recommended us to you? _____

CC: What is the reason for your clinic visit? _____

HPI: Explain the problem in detail: _____

_____

Is there pain present? Yes No (if no, skip next two lines).

❑ Location of pain:
_____
_____

❑ Severity? _____
(Scale 1= mild
10= severe)

❑ When?
at rest
activity related
night pain

❑ What makes it better?
Aspirin other
NSAIDS (motrin)
rest

❑ Quality?
dull
sharp
toothache-like

❑ Duration
days
weeks
months

❑ What makes it worse?
_____
_____

Disability

Tests done/results (x-rays; blood; etc,): _____

Braces and/or Special Equipment: _____

Operations for this problem:	Date:	Surgeon:
_____	_____	_____
_____	_____	_____

PMH: Was patient born on due date? _____

Any health problems during pregnancy, labor and/or delivery? _____

Was child head first or feed first (breech)? _____ C-section? _____ Reason: _____

Dates: When he/she first: sit: _____ crawl: _____ walk: _____ say first words: _____

Please describe if he/she has growth or developmental delay: _____

Other medical problems: Asthma Seizures Heart Pneumonia Vision Psychological

Please explain: _____

List all other surgeries: _____

_____

_____

Current medications and Dosage:

_____

_____

_____

Allergies to medicine: ❑ None

_____

_____

_____

SH:

School: _____ Grade: _____Special Needs:: _____

Sports/other interests? _____

Does he/she live with biological parents? ❑ Yes ❑ No

If no, please explain to better help relate: _____

Mother's Name _____ Occupation: _____

Father's Name:_____ Occupation: _____

Brothers ages:_____ Sisters ages:_____

Has anyone in the family experienced symptoms or complaints similar to those of the patient? _____

Any family health problems?

Stroke	❑ Y ❑ N	Mental Illness	❑ Y ❑ N	Arthritis	❑ Y ❑ N
High Blood Pressure	❑ Y ❑ N	Cancer	❑ Y ❑ N	Seizures	❑ Y ❑ N
Gout	❑ Y ❑ N	Heart Trouble	❑ Y ❑ N	Kidney Trouble	❑ Y ❑ N
Other? _____		Diabetes	❑ Y ❑ N	Alcoholism	❑ Y ❑ N
_____		Bleeding Disorders	❑ Y ❑ N		

Does the patient have problems with any of the following? If yes, please check.

❑ **Constitutional**
Fever
Weight gain
Weight loss
Night sweats

❑ **Respiratory**
Shortness of breath
Cough
Pneumonia

❑ **Cardiovascular**
Chest pain
Abnormal heartbeat
Heart murmur

❑ **Integumentary**
Skin rash
Psoriasis

❑ **Endocrine**
Hyperthyroid
Hypothoyroid
Diabetes

❑ **Eyes**
Reading glasses
Change in vision

❑ **ENT**
Loss of hearing
Nose bleeds
Hoarseness
Difficulty swallowing

❑ **Musculoskeletal**
Neck pain
Lower back pain
Upper extremity pain
Lower extremity pain

❑ **Heme/Lymph**
Easily bleeds

❑ **GI**
Poor appetite
Nausea/vomiting
Stomach pain
Blood in stool
Diarrhea
Constipation

❑ **GU**
Blood in urine
Frequent urination
Burning w/urination
Incontinence

❑ **Psych**
Nervousness
ADD/ADHD
Depression
Insomnia

❑ **Neuro**
Headaches
Weakness
Numbness
Seizures

❑ **Allergy/Immunology**
Seasonal allergies
Hayfever

Form completed by: _____ Relation to Patient: _____

Reviewed by: _____