Medical City Children's
Orthopedics & Spine Specialists

For office use only:
W:_____H:_____T:_____
_____
_____

New Patient History

Please answer all of the questions that you can. If you are unsure or something does not apply, leave it blank.

Patient Information:
Name: Gender: Male Female

Date of Birth: Age:

Referral:
Who referred you to us?

Today's Visit:
What is the reason for your visit?

Symptoms:
Which side is affected? ☐ Right ☐ Left ☐ Both ☐ N/A

When did this start?

Was there a specific injury or inciting event? ☐ Yes (If yes, please describe) ☐ No

Severity of pain? (0 = none, 10 = worst) ___/10

Since they started, symptoms are getting: ☐ Improving ☐ Worsening ☐ About the same

What makes the pain better?

What makes the pain worse?

Prior Testing/Treatment:
Tests done? ☐ X-rays ☐ MRI ☐ CT scan
☐ Other: _____

Prior treatment? ☐ Rest ☐ Ice ☐ Heat
☐ Medication: _____
☐ Cast, splint or brace: _____
☐ Physical therapy: _____
☐ Surgery: _____
☐ Other: _____

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Medical History:
Please list medical conditions, past surgeries or hospitalizations.

Medications: List all of your medications.
Include vitamins, supplements, and over-the-counter medications.

Allergies:
Any medication allergies? ☐ No ☐ Yes: _____

Allergy to latex, metal, or other material? ☐ No ☐ Yes: _____

Family History:
Any family history of orthopedic conditions?

Scoliosis	☐ Yes	☐ No
Hip dysplasia	☐ Yes	☐ No
Clubfoot	☐ Yes	☐ No
Other:	☐ Yes	☐ No

Any medical conditions in the family? ☐ Yes ☐ No
If so, please describe:

Birth History:
Weeks of gestation (Full term?): Delivery: ☐ Vaginal ☐ Caesarean

Birth weight:

Any complications? ☐ Yes ☐ No Please describe:

Developmental History:
Any physical, mental, or speech handicaps? ☐ Yes ☐ No
Please describe:

At what age did your child: Sit without support?
Walk independently?

Menstrual History (Females only):
Has your daughter had her 1st period? ☐ Yes ☐ No
If yes, when did they 1st start?

Social History:
Grade level: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12 College

School Name/Location: Sports or hobbies:

Any alcohol, tobacco, or illegal drug use?

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☐ No ☐ Yes (If yes, please describe)

New Patient History

Review of Systems:
Any of the following medical symptoms? Check all that apply, or "None" for each category.

Constitutional	☐ Fevers/Chills ☐ Fatigue ☐ Recent cold, flu, or other illness (within last 2 weeks) ☐ Other:	☐ None
Eyes	☐ Difficulty seeing ☐ Temporary loss of vision ☐ Other:	☐ None
Ears, Nose, and Throat	☐ Problems with hearing ☐ Nose bleeds ☐ Sore throat ☐ Other:	☐ None
Cardiovascular	☐ Chest pain ☐ Racing heartbeat ☐ Other:	☐ None
Respiratory	☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Other:	☐ None
Gastrointestinal	☐ Constipation ☐ Diarrhea ☐ Frequent heartburn or indigestion ☐ Nausea/Vomiting ☐ Other:	☐ None
Genitourinary	☐ Blood in urine ☐ Pain with urination ☐ Urinary frequency/urgency ☐ Other:	☐ None
Musculoskeletal	☐ Joint pain ☐ Joint swelling ☐ Other:	☐ None
Skin	☐ Rashes ☐ Itching ☐ Other:	☐ None
Neurological	☐ Fainting ☐ Numbness/tingling ☐ Headache ☐ Other	☐ None
Psychiatric	☐ Depressed mood ☐ Anxiety ☐ Other:	☐ None
Endocrine	☐ Recent weight change > 5 pounds ☐ Thyroid problems ☐ Other:	☐ None
Hematologic	☐ Easy bleeding ☐ Other:	☐ None
Allergic/Immunologic	☐ Seasonal allergies ☐ Frequent infections	☐ None

	☐ Other:	

To the best of my knowledge, my answers are correct: _____ _____

Signature (Parent/Guardian) Date

_____ _____

Signature (Provider) Date