Name: ______________________________
DOB: _______________
Chart: _______________

____
Date of Visit

JEWETT ORTHOPAEDIC CLINIC

Child Medical History - Page 1

Age: **Height:** **Weight:** **Primary Physician:**

Please note, items left blank indicate a negative response.

MATERNAL & NEONATAL HISTORY:

Child was pregnancy number: _____ Length of pregnancy: _____ Length of labor: _____ Birth weight: _____

Delivery Location: ☐ Home ☐ Hospital ☐ Other ______________________

Type of Delivery: ☐ Normal ☐ Induced ☐ C-Section

Complications: ☐ None ☐ Breech ☐ Shoulder dystocia ☐ Other ______________

CHILD MEDICAL HISTORY: ☐ None

Indicate **all** medical conditions the child has experienced.

☐ Autism
☐ Attention deficit disorder
☐ Birth defects
☐ Congenital heart disease
☐ Asthma
☐ Pneumonia
☐ Apnea
☐ Seizures
☐ Cerebral palsy
☐ Down's syndrome
☐ Diabetes
☐ Thyroid disorders
☐ Liver disorder
☐ Kidney problems
☐ Bleeding disorders
☐ Other (list in space below)

SURGICAL PROCEDURES: ☐ None

Indicate **all** surgical procedures (include approximate dates).

☐ Ear tubes _______
☐ Appendix _______
☐ Tonsils _______
☐ Colon _______
☐ Hernia _______
☐ Kidney _______
☐ Heart _______
☐ Other (list in space below)

FAMILY HISTORY: ☐ None

Indicate **all** medical conditions experienced by any parent or sibling.

☐ Birth defects
☐ Congenital heart disease
☐ Club foot
☐ Scoliosis
☐ Hip Dysplasia
☐ Bleeding disorders
☐ Frequent fractures
☐ Anesthetic complications

SOCIAL HISTORY:

Child lives with: ☐ Parents ☐ Mother ☐ Father ☐ Other: ______________

School attending: ______________________ Grade level: __________

Tobacco Use: ☐ Never ☐ Current ☐ Previous

REVIEW OF SYSTEMS: ☐ None

Indicate **all** symptoms that the child is presently experiencing.

☐ Fevers/Night sweats
☐ Shaking/Chills
☐ Frequent nosebleeds
☐ Visual problems
☐ Hearing problems
☐ Dizziness/Fainting
☐ Frequent headaches
☐ Constant cough
☐ Shortness of breath
☐ Coughing up blood
☐ Hoarseness
☐ Abnormal heartbeat
☐ Ankle swelling
☐ Calf cramps
☐ Nausea/Vomiting
☐ Stomach pain
☐ Blood in stools
☐ Loose stools
☐ Loss of appetite
☐ Difficulty with urination
☐ Blood in urine
☐ Rashes
☐ Severe itching
☐ Bruising/Bleeding easily
☐ Joint pain
☐ Joint swelling
☐ Bed wetting
☐ Behavior problems

Name: ______________________________

DOB: ______________

Chart: ______________

____
Date of Visit

JEWETT ORTHOPAEDIC CLINIC

Medical History - Page 2

MEDICATIONS: ☐ None List **all prescription** and **non-prescription** medications and **supplements**.

Name of medication	Strength/Dose	Frequency

ALLERGIES: ☐ None Indicate **all** allergies you have to **medications** and **foods.**

Include reaction, i.e. nausea, vomiting, itching, rash, swelling, difficulty breathing

- ☐ Penicillin ______________
- ☐ Sulfa ______________
- ☐ Aspirin ______________
- ☐ Codeine ______________
- ☐ Morphine ______________
- ☐ Iodine ______________
- ☐ Latex ______________
- ☐ Milk ______________

☐ Other - List below

____

Print name of patient (or authorized representative) | Signature of patient (or authorized representative) | Date

Name of Provider | Provider Signature | Date

Name: ______________________________
DOB: _______________
Chart: _______________

____
Date of Visit

JEWETT ORTHOPAEDIC CLINIC

Medical History - Page 3

SUPERCONFIDENTIAL INFORMATION: ☐ None Indicate **all** conditions for which you have received treatment.

☐ Mental health conditions (depression, anxiety, etc.)
☐ Substance abuse (alcohol, narcotics, etc.)
☐ Illegal drug use
☐ HIV / AIDS
☐ Sexually transmitted diseases (STD's)
☐ Minor pregnancies (pregnancy under the age of 18)

If you have indicated any of the conditions above, **please initial** the corresponding categories listed below which will authorize **Jewett Orthopaedic Clinic** to disclose that information to third parties for treatment or payment purposes in the event that it is requested by said third parties or required by law

Initials: __________ Mental health information
Initials: __________ Substance abuse information
Initials: __________ Illegal drug use information
Initials: __________ HIV/AIDS information
Initials: __________ STD information
Initials: __________ Minor pregnancy information

Are you pregnant or could you be pregnant? ☐ No ☐ Yes If yes, due date: _______________

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE TERMS.

Print name of patient (or authorized representative) | Signature of patient (or authorized representative) | Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Name of Provider | Provider Signature | Date