Banner Health®

NEW PATIENT MEDICAL HISTORY
PEDIATRIC ORTHOPEDICS

Patient Name: _____ **Date of Birth:** _____ **Gender: M / F**

Person filling out form and relationship to patient: _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Reason for visit: _____

ALLERGIES

❑ **No known allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

❑ **No Medications**

List any medications you are taking, with dose and how often. List any Vitamins, Supplements and Over the Counter Medicines

Medication Name:	**Dose:**	**How often?**

PATIENT MEDICAL HISTORY

List any current or past medical conditions, including broken bones (please place checkmark by any current problems).

❑ _____

❑ _____

❑ _____

❑ _____

❑ _____

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0131
(01/2017)

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SURGERIES AND/OR HOSPITALIZATIONS

Has your child had any surgeries or has been hospitalized? (provide dates and reason below)?

Date:	Reason:	Date:	Reason:

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				
Brother				
Sister				

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

(For patients 13 and older)

Tobacco/smoking status:	❑ Never				
	❑ Current	Type	Amount	Duration	
	❑ Former	Type	Amount	Duration	
Do you use alcohol?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use Caffeine?	❑ No	❑ Yes	Type	Amount	Frequency

MENSTRUAL HISTORY

(Females Only)

Has your child ever had a menstrual period?	❑ Yes	❑ No	If yes, age of onset	Date of last period
Are they regular (every month)?	❑ Yes	❑ No	If no, explain:	
Length of period?	❑ less than 5 days	❑ 5-7 days	❑ more than 7 days	
Character of bleeding	❑ Light	❑ Moderate	❑ Heavy	

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REVIEW OF SYSTEMS

CONSTITUTIONAL			GASTROINTESTINAL			SKIN		
Chills	Yes	No	Bloody stools	Yes	No	Itching	Yes	No
Fatigue	Yes	No	Constipation	Yes	No	Poor healing	Yes	No
Fever	Yes	No	Diarrhea	Yes	No	Rash	Yes	No
Unexpected weight loss	Yes	No	Heartburn	Yes	No	Redness	Yes	No
Weight gain	Yes	No	Nausea	Yes	No	Skin changes	Yes	No
EYES / ENT			Vomiting	Yes	No	**NEUROLOGICAL**		
Blurred/double vision	Yes	No	**GENITOURINARY**			Dizziness	Yes	No
Corrective lenses	Yes	No	Bleeding	Yes	No	Numbness/tingling	Yes	No
Difficulty swallowing	Yes	No	Difficult/painful urination	Yes	No	Seizure	Yes	No
Earaches	Yes	No	Flank pain	Yes	No	Tremors	Yes	No
Eye pain	Yes	No	Unable to control urination	Yes	No	Unsteady gait	Yes	No
Headache	Yes	No	**HEMATOLOGIC**			**PSYCHIATRIC**		
Nose bleeds	Yes	No	Bruising	Yes	No	Depression	Yes	No
Redness	Yes	No	Easy bleeding	Yes	No	Hallucinations	Yes	No
Ringing in ears	Yes	No	**ENDOCRINE**			Nervousness/anxiety	Yes	No
Watering	Yes	No	Excessive thirst/urination	Yes	No	**ALLERGIC**		
RESPIRATORY			Heat/cold intolerance	Yes	No	Environment allergies	Yes	No
Cough	Yes	No	**MUSCULOSKELETAL**			Food allergies	Yes	No
Inspiration pain	Yes	No	Bone pain	Yes	No			
Short of breath	Yes	No	Joint pain	Yes	No			
Snoring	Yes	No	Joint redness/warmth	Yes	No			
Tightness	Yes	No	Joint stiffness	Yes	No			
Wheezing	Yes	No	Joint swelling	Yes	No			
CARDIOVASCULAR			Loss of range of motion	Yes	No			
Chest pain	Yes	No	Muscle pain	Yes	No			
Fainting	Yes	No	Muscle weakness	Yes	No			
Murmur	Yes	No						
Palpitations	Yes	No						

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