

Orthopaedic Surgery Specialists, Ltd. - Pediatric Pre-Evaluation Form

Patient Name _____ Age _____ Date of Birth ____/____/____

Your pediatrician's name and phone number: _____

What is the reason for your visit today? _____

When was the onset of your child's problem/injury? _____

Has your child had previous treatment for this problem/injury? (i.e. ER, Pediatrician) _____

Your child's birth history:

Birth Weight: _____ pounds, _____ ounces Premature? Yes No

Cesarean Section? Yes No Vaginal Delivery? Yes No

Breech Delivery? Yes No Normal Presentation? Yes No

Your child sat up at _____ months, walked at _____ months

Mom's number of pregnancies: _____, number of children _____

Are your child's immunizations up to date? _____

Does your child have any allergies to medications that you are aware of and if so, what are they and what is the reaction? _____

Is your child currently taking any medications and if so, what are they? _____

Does your child have any medical problems and if so, what are they? _____

Has your child had any hospitalizations or injuries? If so, please list. _____

Is there any significant family medical history the doctor should be aware of? (i.e. cancer, heart disease)

Is your child active in any sports/recreation activities in school or outside of school? If so, please list.

***If you have any other pertinent information that you would like to share with the doctor, please use the backside of this form.**