# Dr. Hess/Dr. Garcia Pediatric Form

Medical Notes

Child's Preferred Name: ________________________________________
Child's age: Years ________/Months ____________ Race: _____________
Height: ________________ Weight: _____________________________

## ORTHOPAEDIC / BURN HISTORY

Describe current problem: ________________________________________________________
_______________________________________________________________________________

Has your child received any treatment for this problem? ☐ No ☐ Yes:
Explain: ______________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

What are your expectations of today's visit and your care at Florida Orthopaedic Institute?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

## MEDICAL/SURGICAL HISTORY

Has your child currently or ever had any of the following conditions? ***(Check all that apply)***

☐ Abnormal bleeding/bruises
☐ Anxiety
☐ Arthritis
☐ Asthma/Breathing problems
☐ ADD/ADHD
☐ Balance problems
☐ Bloody stools
☐ Bone/joint infection
☐ Broken bones
☐ Cancer
☐ Chronic constipation
☐ Chronic Diarrhea
☐ Chronic upset stomach
☐ Depression
☐ Diabetes
☐ Delayed development
☐ Ear infections
☐ Heart murmur
☐ Heart problem
☐ Kidney Failure
☐ Kidney infection
☐ Moles/Birthmarks
☐ Numbness or tingling
☐ Seizures
☐ Shunt
☐ Skin Rashes
☐ Speech problems
☐ Suicide attempt
☐ Swollen joints
☐ Thyroid problems
☐ Trouble controlling bladder
☐ Trouble controlling bowels
☐ Trouble feeding
☐ Trouble hearing
☐ Trouble seeing
☐ Urinary tract infection
☐ Weight loss
☐ Weight gain (excessive)
☐ Wounds

List any previous surgeries or hospitalizations: ________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

If your child's had surgery, were there any problems with anesthesia? ☐ No ☐ Yes:
Describe: ______________________________________________________________________
Has your child ever had a blood transfusion? ☐ No ☐ Yes: Why? _________________________
Are your child's Immunizations up to date? ☐ Yes ☐ No ***(Bring shot record to first visit)***
Does your child have or have they ever been exposed to the following:

☐ MRSA/VRE (Resistant Infection)
☐ Sexually Transmitted Diseases
☐ CMV
☐ Tuberculosis
☐ Hepatitis A/B/C
☐ Chicken Pox

Medical Notes

## FAMILY MEDICAL HISTORY

Do any members of your child's immediate family have any health problems, birth defects, or allergic reactions to anesthesia? ***(Parents, Grandparents, Brothers, Sisters which are blood relatives)***
☐ No ☐ Yes, if yes please list: ______________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

## PSYCHOSOCIAL HISTORY

Legal Guardians: ____________________________________/ ______________________________
Child lives with: _____________________________________Relationship: ___________________
Number of Brothers: __________________________________Ages: _________________________
Number of Sisters ____________________________________Ages: _________________________
Is English your primary language? ☐ Yes ☐ Other: _______________________________________

## GROWTH AND DEVELOPMENT/FUNCTIONAL HISTORY

Age your child first/ Sat alone:______ Walked with help: ______ Walked independently: _______
Does your child use any of the following:

☐ Braces ☐ Crutches ☐ Shoe Inserts/Lift
☐ Splints ☐ Walker ☐ Wheelchair
☐ Prosthesis ☐ Canes ☐ Talking Device

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Does your child receive any of the following therapies, if so how often?
☐ Physical ______________________ ☐ Occupational ____________ ☐ Speech ______________
These activities can be done independently by my child: *(check all that apply)*

☐ Walking ☐ Sitting ☐ Toileting
☐ Feeding ☐ Dressing ☐ Hygiene needs

First menstrual period: ☐ N/A Date: ______________________ Age: _____________________
Grade in school: _____________ ☐ N/A (too young) Special Education: ☐ No ☐ Yes
Does your child attend school regularly? ☐ Yes ☐ No
School concerns: ________________________________________________________________
_____________________________________________________________________________
Additional concerns: _____________________________________________________________

## ALLERGIES

Allergies ☐ No ☐ Yes: If yes please describe the type of reaction that happens

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Latex Allergy ☐ Yes ☐ No Latex Precautions ☐ Yes ☐ No

## MEDICATIONS

Please list all medicines, vitamins, herbs and supplements your child takes regularly:

| Name of medicine | How much is given | Reason for taking |
|---|---|---|
| | | |
| | | |
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| | | |
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| | | |

## BIRTH HISTORY

Did your child's mother receive pre-natal care during the pregnancy? ☐ Yes ☐ No
Birth weight: Pounds ______ Ounces _____ Length in inches ____________
Was child born on due date? ☐ After ☐ On ☐ Before, how many weeks? _______________
Type of Delivery: ☐ Vaginal ☐ Cesarean Section, Why? ____________________________
Was the baby born breech? (not coming out head first) ☐ Yes ☐ No
Did the mother take any medications during the pregnancy? ☐ No ☐ Yes, what type? _____
______________________________________________________________________________
______________________________________________________________________________
Were there any problems during the pregnancy? ☐ No ☐ Yes, explain: _________________
______________________________________________________________________________
Were there any problems during the delivery? ☐ No ☐ Yes, explain: ___________________
______________________________________________________________________________
Was the child in NICU? ☐ No ☐ Yes, How Long? _________________________________
Did the child need help to breathe at birth? ☐ No ☐ Yes, Ventilator? __________________
How long? _____________________________________________________________________

History form completed by: _______________________________________Date: ___________

***(Staff use only)*** Reviewed by: ____________________________________Date: ______________

| Medical Notes |
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