

**Douglas S. Skura, MD**

**Marysville Orthopedics**

**Orthopedic and Health Assessment for Children**

Please complete this detailed form to assist your Doctor. The details of your medical history will be helpful in arriving at a more precise diagnosis, to suggest appropriate testing and to evaluate your possible medical risks if surgery is needed. Please ask for assistance if you need help in completing this form. Thank you for your time.

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_ Job Duties \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Primary Language Spoken \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

\_\_\_\_\_ Right Left Both

Please describe your current symptoms, orthopedic problem(s) or concerns \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your problem due to an accident? Yes No If yes, where did the accident occur? \_\_\_\_\_

\_\_\_\_\_

Have you missed work or school because of your injury? Yes No

Last day worked? \_\_\_\_\_ Were you seen in an ER for this injury? Yes No

List any treatments or medications you have tried for the above problem(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had x-rays, MRI, or other tests? Yes No

If yes, where? Dates? \_\_\_\_\_

List any medical problems that you have been treated for in the past or being treated for in the present \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all current and/or previous treating physicians \_\_\_\_\_

\_\_\_\_\_

List any previous surgeries and dates (all types) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specific concerns or questions you would like to address? \_\_\_\_\_

Name: \_\_\_\_\_

Please provide a list from home or write below all medications with dosages and intervals(once a day, twice a day, etc.). Please include prescription, over the counter, vitamins and alternative medications.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES:** Are you allergic or react adversely to any of the below?

Latex	Yes	No	Reaction: _____
Penicillin	Yes	No	Reaction: _____
Sulfa Drugs	Yes	No	Reaction: _____
Adhesive Tape	Yes	No	Reaction: _____
Aspirin/NSAIDs	Yes	No	Reaction: _____
Eggs/Feathers	Yes	No	Reaction: _____
Flu Shots	Yes	No	Reaction: _____
Novacaine	Yes	No	Reaction: _____
Cortisone	Yes	No	Reaction: _____
Tetracycline	Yes	No	Reaction: _____
Iodine Dye	Yes	No	Reaction: _____
Other (s)	_____		

Do you get nauseated, vomit or other adverse reactions with narcotic pain meds, surgery or anesthesia?

Yes                  No                  Type \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Please circle yes or no, and list type of problems. PLEASE, do NOT leave any blank.

Current Infection	Yes	No	Where & When _____
Recent Weight Change	Yes	No	Loss/Gain (circle)      Amount _____ lbs
Problem Headaches	Yes	No	Migraines/Other (circle) _____
Seizures (ever)	Yes	No	When & Cause _____
Cancer	Yes	No	Type _____ Year _____
Asthma	Yes	No	Current OR Past

NAME: \_\_\_\_\_

Previous Pneumonia	Yes	No	When? _____
Arthritis	Yes	No	Type _____
Diabetes	Yes	No	Year Diagnosed _____
Recent Appetite Changes	Yes	No	Increased      Decreased
GERD/Reflux	Yes	No	Treated?      Yes      No
GI Ulcer (ever)	Yes	No	Year _____ Esophagus    Gastric    Duodenal
GI Bleeding (ever)	Yes	No	Upper                  Lower                  Unknown
Urinary Tract Infection	Yes	No	Last one? _____ Recurrent? _____
Kidney Failure	Yes	No	Nephrologists name _____ Dialysis ___ Yes    No
Viral Hepatitis	Yes	No	Type _____ Active                  Yes      No
Blood Clotting Disorder	Yes	No	Factor V (five)Leiden                  Yes      No
Thyroid Disorders	Yes	No	Hypo (low)                  Hyper (overactive)
Prior Blood Transfusion(s)	Yes	No	If Yes, when _____ Reason _____
Solid Organ Transplant	Yes	No	Type _____ Reason _____ Date _____
Hard of Hearing	Yes	No	If yes, Hearing Aids      Yes                  No
Rash/Skin Conditions	Yes	No	Acne ___ Eczema ___ Psoriasis ___ Other ___

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Recent Fever	Yes	No	Recent Dizziness	Yes	No
Paralysis	Yes	No	Contacts	Yes	No
Glaucoma	Yes	No	Eye Glasses	Yes	No
Breathing Problems	Yes	No	Emphysema	Yes	No
Home O2 (oxygen)	Yes	No	Rheumatic Fever	Yes	No
Irregular Heart Beat	Yes	No	Mitral Valve Prolapse	Yes	No
Fainting	Yes	No	Shoulder Problems	Yes	No
Back Problems	Yes	No	Knee Problems	Yes	No
Unsteady Walk/Falls	Yes	No	Recurrent Constipation	Yes	No
Recent Diarrhea	Yes	No	Gall Bladder Disease	Yes	No
Trouble Swallowing (Food/Pills)	Yes	No	Jaundice	Yes	No
Liver Problems	Yes	No	Urinary Incontinence	Yes	No
Trouble Voiding	Yes	No	Kidney Stones	Yes	No

NAME: \_\_\_\_\_

Excess Bleeding Disorder	Yes	No	Anemia (blood disorder)	Yes	No
Slow Healer	Yes	No	ADHD	Yes	No
Bipolar Disorder	Yes	No	Schizophrenia	Yes	No
Learning Disability	Yes	No	Depression	Yes	No
Anxiety Disorder	Yes	No	Cerebral Palsy	Yes	No

**\*\*\*\*\* Immunizations Up to Date      Yes      No\*\*\*\*\***

### **SOCIAL HISTORY**

How much caffeine do you consume in one day? \_\_\_\_\_

Do you use tobacco products?      Yes      No      How long have you used? \_\_\_\_\_

If yes to above,      Cigarettes      Cigars      Chewing Tobacco      How much per day? \_\_\_\_\_

Are you interested in quitting smoking or chewing?      Yes      No      Maybe

Do you drink alcohol containing beverages?      Yes      No      How much per day? \_\_\_\_\_ Type \_\_\_\_\_

Social inhaled and/or street intravenous drugs (past or present)      Yes      No

Type and when \_\_\_\_\_

Do you have a high stress level?      Yes      No      Do you feel you are handling it well?      Yes      No

### **FAMILY MEDICAL HISTORY**

**Please list ANY and ALL known diseases that run in your family including abnormal reactions to surgery, such as prolonged time to wake up from anesthesia or severe fevers (Malignant Hyperthermia).**

Mother's Side (Patient's mother, aunts and uncles) \_\_\_\_\_

Father's Side (Patient's father, aunts and uncles) \_\_\_\_\_

Siblings (Patient's brother/sisters) \_\_\_\_\_

Are your parents still living?      Mother      Yes      No      Father      Yes      No

If not, age and cause of death \_\_\_\_\_