

RANDALL J. ROGALSKY, M.D.

DEBBIE SEYMOUR, CNP

PEDIATRIC ORTHOPEDICS

(Age 14 and Under)

Name _____ Birthdate _____ Age _____

Sex _____ Height _____ Weight _____ Social Security No. _____

Pediatrician _____ Insurance _____ Referred by _____ Date first seen _____

Hospital _____ Obstetrician _____

Father's Name: Age:	Address : _____	Home Phone:
Father's SS#:	Employer: Occupation	Work Phone:
Mother's Name: Age:	Address : _____	Home Phone:
Mother's SS#:	Employer: Occupation	Work Phone:
Mother's Date of Birth:	Father's Date of Birth:	Pharmacy:
Siblings: Age:	Siblings: Age:	Siblings: Age:
Siblings: Age:	Siblings: Age:	Siblings: Age:

Current Problems _____

IMMUNIZATIONS

ALLERGIES

Up to Date _____ List any known _____
Partial _____
Never _____

Use back of form for additional siblings if necessary.

FAMILY HISTORY
IS THERE A HISTORY IN YOUR FAMILY OF:

Anesthetic Problems _____ Cancer _____
Early heart attack (before age 60) _____ Bleeding Disorders _____
Early stroke (before age 60) _____ Sickle Cell Anemia _____
Diabetes _____ Arthritis _____
High blood pressure _____ Other _____

PAST HISTORY

Please List Any Problems, Treatment and Dates of Occurrence:
Illnesses _____
Surgery _____
Previous injuries _____
Medications _____

UPDATED BY PARENT/GUARDIAN	DATE:	REVIEWED DATE:
Signature:		
Signature:		
Signature:		
Signature:		
Signature:		
Signature:		

OFFICE USE ONLY

PROBLEM LIST

IMMUNIZATION AND SKIN TESTING

Neonatal Screen		Lead Level		TB		PPD		HCT	
Date	Result	Date	Result	Date	Result	Date	Result	Date	Result

Tetramune	DPT	dt	OPV	HIB	Hepatitis B	MMR	Varicella	Other	Other Date