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

Up to Date_____
Partial_____
Never_____

ALLERGIES

List any known_____
_____
_____

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