Rocky Mountain Pediatric Orthopedics
Rocky Mountain Youth Sports Medicine Institute
Rocky Mountain Center for Concussion

Patient Medical History

Today's Date: _____ **Primary Care Physician: _____**

Patient's Name: _____ DOB: _____ Gender: _____ Age: _____

Grade in School: _____ Birth Weight: _____ Dominant Hand: _____ Height: _____ Weight: _____

School Name: _____ School District: _____

Reason for today's visit (Chief Complaint): _____

_____

How did it occur: _____

Is this a: ❑Recent Injury(with in last month) ❑Old Injury ❑On-going problem/pain ❑Second Opinion

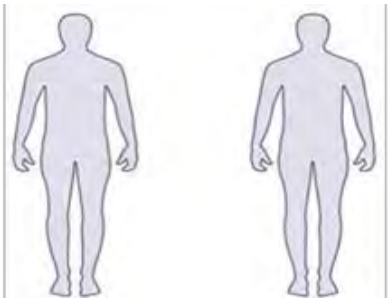
Which Side: ❑Right ❑Left ❑Bilateral (both) BODY PART(s):_____

Date of Injury/Pain Began: _____

Did you have: ❑X-RAYS ❑CT SCAN ❑MRI ❑Labs ❑None ❑Other_____ Do you have them with you? ❑Yes ❑No

Did you visit an Emergency Department/ Urgent Care? ❑Yes ❑No Facility Name: _____Date: _____

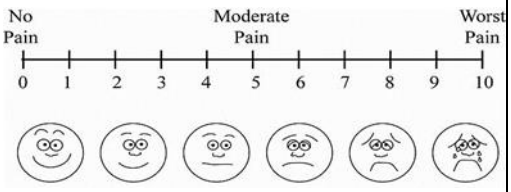
FRONT	**BACK**
RIGHT LEFT	LEFT RIGHT



Describe your pain/symptoms:

- ☐ Shooting
- ☐ Tingling
- ☐ Numb
- ☐ Stabbing
- ☐ Dull
- ☐ Stinging
- ☐ Burning
- ☐ Aching
- ☐ Sharp

What is your pain level today?



What makes the pain better? _____ What makes the pain worse? _____

Received treatment for this Injury/Problem? ☐ Yes ☐ No If Yes, please choose the following options:

☐ Tylenol/Ibuprofen ☐ Pain Medication ☐ Compression (Ace Wrap) ☐ Elevation ☐ Physical Therapy

☐ Splinted/ Temp Cast ☐ Ice ☐ Crutches ☐ Other: _____

Medical Information

Medical Problems: _____

_____

Current Medication:

_____

***Please see the back of the page for additional medication.

Dose & Frequency:

_____

Allergies & Reactions: _____

Surgeries and Dates: _____

_____

Hospitalization and Dates: _____

Medication:	Dose:	Frequency:

Family History

Parent's/Guardian's Name: _____	Occupation: _____
Parent's/Guardian's Name: _____	Occupation: _____

Please indicate which family member has the below family history:

1. **Orthopedic Problems** – Mom, Dad, Brother, Sister	2. **Scoliosis** – Mom, Dad, Brother, Sister
3. **Hip Dysplasia** – Mom, Dad, Brother, Sister	4. Diabetes – Mom, Dad, Brother, Sister
5. Hypertension – Mom, Dad, Brother, Sister	6. Breast Cancer – Mom, Dad, Brother, Sister
7. Coronary Artery Disease – Mom, Dad, Brother, Sister	8. Lung Cancer – Mom, Dad, Brother, Sister
9. Colon Cancer – Mom, Dad, Brother, Sister	10. Heart Attack – Mom, Dad, Brother, Sister
11. High Cholesterol – Mom, Dad, Brother Sister	12. Asthma – Mom, Dad, Brother, Sister
13. Other: _____ Mom, Dad, Brother, Sister	

Mom: Alive / Deceased	Dad: Alive / Deceased	Sister(s): Alive / Deceased	Brother(s): Alive / Deceased

Social History

Who lives with you: _____

Tobacco/Nicotine Use: **(13 and Older)** ☐ Never ☐ Current ☐ Former

Sports/Hobbies: _____

Do you exercise? ☐ Yes ☐ No _____ Days per week you exercise. _____ Hours per day you exercise.

Name of Sports Organization/Team: _____

Immunizations

Influenza (All Ages) ☐ Yes/Month and Year:_____ ☐ No ☐ Refused

Immunizations up to date? ☐ Yes ☐ No

Review of Systems (Past & Present)

☐ *Check if all are Negative*

Psychiatric:
- ☐ Depression
- ☐ Emotional Difficulties

Respiratory:
- ☐ Coughing
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Wheezing

Hematologic:
- ☐ Bleeding Problems
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Clotting Problems

Gastrointestinal:
- ☐ Stomach Pain
- ☐ Heart Burn

Genitourinary:
- ☐ Blood in Urine
- ☐ Urinary Difficulties

Dermatologic:
- ☐ Rash
- ☐ Eczema
- ☐ Keloids/Hypertrophic Scarring

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Murmur

Eyes, ears, nose, throat:
- ☐ Vision/Hearing problems
- ☐ Nose Bleeds
- ☐ Sinus Problems

Constitutional symptoms:
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Night Sweats

Musculoskeletal:
- ☐ Joint/Muscles Aches

Neurologic:
- ☐ Balance Problems
- ☐ Seizure
- ☐ Other: _____
  _____

Endocrine:
- ☐ Low/High Blood Sugar
- ☐ Low/High Thyroid Functioning

☐ **Cancer:**_____ ☐ **Other:**_____

Signature of Patient/Responsible Party: _____ **Date:** _____