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PLEASE FILL OUT COMPLETELY

CHILD'S NAME _____ NICK NAME _____
REFERRING M.D. _____ PEDIATRICIAN _____
REASON FOR VISIT/PROBLEM _____

LEGAL GUARDIANS: PARENTS OTHER RELATIVES NOT RELATED
NAME _____

TELEPHONE HOME _____ WORK _____

Who is responsible for making medical
decisions _____

Who lives at home _____

Who cares for child at home _____

Who cares for child when parents are at work _____

Are there any socialization/school issues? yes no. If yes, please explain _____

Does your child have any allergies or sensitivity to any medications, food, latex, other?
 yes no If yes, please list allergy and reaction _____

Has your child had a previous blood transfusion? yes no

Does your child have any bleeding problems? yes no

Does your child have any health problems? yes no if yes, please list and explain _____

Has your child had any prior surgeries? yes no If yes, please list _____

Girls menarche (at what age did menstrual periods begin)

What is your child's recent height _____ and weight _____

Has your child been exposed to any infectious diseases within the last month? (i.e.
chicken pox, measles, mumps, rubella, tuberculosis...) yes no If yes, please list:

Are your child's immunizations up to date? yes no

Does your child take medications on a daily basis(including vitamins, herbal
supplements, teas) yes no If yes please list medication, dosage, and frequency

Does your child or anyone in the house smoke? yes no

Does your child or anyone in the house drink alcohol yes no if yes, how often _____

If child is 6 or less, or less than 60 lbs- do they use a car seat? yes no N/A

Does your child wear a seatbelt in the car? yes no