Print Form

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

Today's Date: _____ Child's Name: _____

Please complete this questionnaire. This information will assist your doctor and the outpatient staff to evaluate and treat your problem.

Child's age: _____ Birthdate: _____

What is your child's problem? _____

What do you expect your visit to accomplish? _____

When did your child's problem begin? _____

How did your child's problem start? (If problem is an injury, please describe):

Describe treatment up until now, and give approximate dates:

Is the problem getting ☐ better ☐ worse ☐ or staying the same? (please check one)

What makes it worse?

What makes it better?

What **can't** your child do because of this problem?

PAST HISTORY:

Has your child ever had or does he/she now have:

- ☐ High blood pressure
- ☐ Born with a heart or other organ abnormality
- ☐ Too much sugar
- ☐ A contagious disease

Was your child born with a disease or disorder of:

- ☐ Blood
- ☐ Bones
- ☐ Genes
- ☐ Grown pattern
- ☐ Cancer Part of the body _____
- ☐ Other diseases we should know about _____

Has your child ever had a blood transfusion? ○ Yes ○ No

List all medications your child is currently taking:

Name	**Dose**

List all allergies your child has to:

Medications	**Other**

Does your child smoke? ○ Yes ○ No
Does your child drink? ○ Yes ○ No
Does your child take street drugs? ○ Yes ○ No

Did the mother smoke while pregnant? ○ Yes ○ No
Did the mother drink while pregnant? ○ Yes ○ No
Did the mother take street drugs while pregnant? ○ Yes ○ No

Please list all surgeries your child has had and the dates:

_____

_____

Please list all injuries with dates and treatments:

_____

_____

For age 10 and younger

Was the delivery of this child: ○ On time ○ Early ○ Late

Was the birth normal? ○ Yes ○ No Child's birth weight: _____

Does your child have any special dietary needs? _____

If your child is under one year of age, specify if the diet is: ☐ breast ☐ formula

Please list date and types of any immunizations:

TYPE	DATE	TYPE	DATE

Does your child have a latex allergy? ◯ Yes ◯ No

FAMILY MEDICAL HISTORY:

	If alive:					If deceased:	Cause:
Father:	Age: ____	Health (select one):	☐ Good	☐ Fair	☐ Poor	Age: ____	_____
Mother:	Age: ____	Health (select one):	☐ Good	☐ Fair	☐ Poor	Age: ____	_____
Siblings:	Age: ____	Health (select one):	☐ Good	☐ Fair	☐ Poor	Age: ____	_____
	Age: ____	Health (select one):	☐ Good	☐ Fair	☐ Poor	Age: ____	_____
	Age: ____	Health (select one):	☐ Good	☐ Fair	☐ Poor	Age: ____	_____
	Age: ____	Health (select one):	☐ Good	☐ Fair	☐ Poor	Age: ____	_____

Have **your** blood relatives had any of the following?

☐ Allergies	☐ Congenital abnormalities	☐ Blood dyscrasia	☐ High blood pressure	☐ Heart attacks
☐ Strokes	☐ Rheumatic fever	☐ Tuberculosis	☐ Epilepsy	☐ Alcoholism
☐ Cancer	☐ Kidney disease	☐ diabetes	☐ Arthritis and/or gout	☐ Asthma

SOCIAL BACKGROUND:

Highest grade in school: _____ Sports activities: _____

_____

Have you ever lived outside the United States? ◯ Yes ◯ No

Current residence: _____

_____

Pediatrician(s): _____

Is your child: ☐ shorter than average ☐ average height ☐ tall for age

***For age five and under**:*

At what age did your child sit _____ walk _____ speak clearly _____

Adolescents:

At what age did breast development begin in your female child? _____

At what age did hair development/voice change begin in your male child? _____

REVIEW OF SYSTEMS:	Yes	No	How long?
Is your child easily fatigued?	○	○	
Has child had unexplained weight loss or gain?	○	○	
Does child have a fever?	○	○	
Does child have any lumps in the neck, armpit or groin area?	○	○	
Does child complain of chest pains?	○	○	
Has child ever had a heart murmur	○	○	
Does child have difficulty exercising?	○	○	
Does child complain of headaches?	○	○	
Has child ever had a seizure?	○	○	
Has child ever been paralyzed?	○	○	
Does child have a runny nose?	○	○	
Does child have frequent ear infections?	○	○	
Does child have frequent sore throats?	○	○	
Does child act short of breath?	○	○	
Has child ever had asthma or wheeze-like breathing?	○	○	
Does child have a cough?	○	○	
Has child ever had pneumonia?	○	○	
Does child complain of pain with urination?	○	○	
Does child have blood in his/her urine?	○	○	
Has child ever had blood in his/her urine?	○	○	
Does child seem to urinate too often?	○	○	
Does child complain of having to urinate all the time, but can't?	○	○	
Is child potty-trained?	○	○	
Does child wet the bed at night?	○	○	
Does child complain of a stomach ache?	○	○	
Has child thrown up, had diarrhea, or constipation recently?	○	○	
Has child ever passed blood with bowel movements?	○	○	
Has child ever been jaundiced?	○	○	
Does child have any sore on his/her body?	○	○	
Does child have a rash?	○	○	
Does child complain of difficulty moving any limb?	○	○	
Does child have weakness in any limb?	○	○	
Does one limb look smaller than the other?	○	○	

Reviewed by: _____ Date: _____
Provider's signature

Printed name: _____