HSS HOSPITAL FOR SPECIAL SURGERY

INITIAL VISIT

PEDIATRIC QUESTIONNAIRE

Brett Toresdahl, MD

Name: ______________________ Age: ________ Today's Date: ____________

Were you referred to Dr. Toresdahl by another healthcare provider? □ Yes □ No

If yes, who referred you? ______________________________

Would you like the referring provider to be sent notes from today's visit? □ Yes □ No

Current Problem: ______________________________

Which side is affected? □ Right □ Left □ Both

When did the injury occur or symptoms begin? ______________________________

How did the injury occur or symptoms begin? ______________________________

____

____

What is the status of your symptoms, e.g., stable, improving, worsening? ______________________________

When are your symptoms most severe, e.g., morning, evening, at night? ______________________________

What makes your symptoms better? ______________________________

What makes your symptoms worse? ______________________________

Rate your pain on a scale of 0-10 (0 = no pain, 10 = extreme pain):

Right now: ________ At best: ____________ At worst: ________

What is the quality of your pain, e.g., sharp, dull, burning? ______________________________

Is the pain constant or intermittent? ______________________________

What other symptoms do you have, e.g., stiffness, weakness, popping, swelling, numbness, tingling? ____________

____

Have you seen another physician for your injury/symptoms? □ Yes □ No

If yes, please describe: ______________________________

Have you experienced anything similar to this in the past? □ Yes □ No

If yes, please describe: ______________________________

Have you had any of the following tests or treatments for this problem?

Tests	*Date(s) of your tests*	*Treatments*	*Describe the treatment – did it help?*
□ X-ray	____________	□ Medications	____________
□ MRI	____________	□ Injections	____________
□ CT scan	____________	□ Surgery	____________
□ Bone scan	____________	□ Physical therapy	____________
□ Ultrasound	____________	□ Bracing	____________
□ Other	____________	□ Other	____________

Medical History

Please list your medical problems, e.g., asthma, allergies, high blood pressure, depression, ADHD, etc.: ___________

____

____

Surgical History

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe: ____

Family History

Please list the medical problems of your immediate family, e.g., arthritis, bleeding problems, cancer, diabetes, heart disease, high blood pressure, neurologic problem, osteoporosis, etc.:

Mother: ____

Father: ____

Sibling(s): ____ ☐ Not applicable

Social History

School: ________________________________ Grade: _______ Number of siblings: _________

Sports/extracurricular activities: ____

Before your current injury/symptoms, please describe your typical physical activity: ______________________

____

Are there any upcoming events that may affect your treatment plan, e.g., race, competition, travel? _______________

____

Medications

Please list your current medications, both prescription and over-the-counter: ___________________________

____

Please list any supplements that you take regularly: ____

Allergies

What medications are you allergic to? ____

Are you allergic to contrast dyes? ☐ Yes ☐ No Are you allergic or sensitive to latex? ☐ Yes ☐ No

Review of Systems

Please check any symptom below that you are currently experiencing or have experienced in the past few weeks:

Symptom			Symptom		
Abdominal pain	☐ Yes	☐ No	Headache	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No
Balance problem	☐ Yes	☐ No	Hot flashes	☐ Yes	☐ No
Blood clot	☐ Yes	☐ No	Irregular heartbeat	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Joint pain	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Joint stiffness	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No	Skin infection	☐ Yes	☐ No
Fever/chills	☐ Yes	☐ No	Weight loss	☐ Yes	☐ No

What goals do you have for today's visit? ____

____

____

Patient Signature: ______________________________ **Date:** ____________________

Physician Signature: ____________________________ **Date:** ____________________