34474-08

Children's Healthcare of Atlanta
Children's Physician Group - Orthopaedics

HIP INTAKE FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Date Completed: _____

Patient History

Patient Last Name: _____ First Name: _____ Date of Birth: _____

Age: _____ What body part is injured? _____

PRIMARY CARE PROVIDER (PCP) INFORMATION:

PCP Name: _____ Name of PCP Practice: _____

PCP Phone Number: _____ PCP Address: _____

HISTORY OF INJURY

Is the injury CHRONIC? ☐ Yes ☐ No If YES, how long has it been going on for? _____

Is the injury NEW as a result of a specific injury? ☐ Yes ☐ No If YES, date of injury:_____

Describe in your own words how the initial injury occurred and how it limits your current level of activity:

Please rate your pain on a scale of 1 to 10 *(10 being the most painful)* At rest: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: ☐ Worsening ☐ Stable Improving ☐ Constant ☐ Occasional ☐ Sharp ☐ Dull
☐ Aching ☐ Stabbing ☐ Throbbing

What symptoms are you experiencing? ☐ Locking ☐ Catching ☐ Giving Way ☐ Popping ☐ Grinding
☐ Bruising ☐ Numbness ☐ Tingling ☐ Other _____

What, if anything, makes your symptoms better? ☐ Rest ☐ Activity ☐ Cold Therapy ☐ Heat Therapy
☐ Medication ☐ Other _____

What, if anything, makes your symptoms worse? ☐ Inactivity ☐ Exercise (explain) _____
☐ Other _____

Have you seen another physician for this injury? ☐ Yes ☐ No If YES, who: _____

What treatments have you tried? ☐ Nothing ☐ Physical Therapy ☐ Decreased Activity ☐ Bracing
☐ Injections ☐ Ice ☐ Exercise ☐ Medications _____

Recreational Activities:

Current, regular exercise program (if any):

Have you had any of the following test/studies?

Test	Date (month/year)	What facility? (clinic/hospital)
☐ X-Ray		
☐ MRI Scan		
☐ CT Scan		
☐ EMG/NCV		
☐ Blood Tests		
☐ Other		

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PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

	When?		*When?*
☐ High Blood Pressure	_____	☐ Seizures	_____
☐ Deep Vein Thrombosis	_____	☐ Asthma	_____
☐ Recent fever	_____	☐ Thyroid ☐ Hypo ☐ Hyper	_____
☐ Eczema	_____	☐ Tuberculosis	_____
☐ Cancer (where?)	_____	☐ Concussions	_____
☐ Elevated Cholesterol	_____	☐ Joint Pain/Fractures	_____
☐ Ulcer Disease	_____	☐ Chest Pain	_____
☐ Gastritis	_____	☐ Irregular Heart Beat	_____
☐ Reflux Disease (GERD)	_____	☐ Weight Loss/Gain	_____
☐ Kidney/Bladder/Urinary Problems	_____	☐ Vomiting/Constipation	_____
☐ Other	_____		

PAST SURGICAL HISTORY

Please list all surgeries you have had in the past:

Type of Surgery	Date	Surgeon

ALLERGIES

Are you allergic to any medication? ☐ Yes ☐ No known drug allergies

If yes, list all medication that you are allergic to and the associated reaction (i.e. Penicillin (hives) etc.):

_____

Are you allergic to: Sulfa? ☐ Yes ☐ No Latex? ☐ Yes ☐ No

Please list all food allergies:

_____

MEDICATIONS

Please list all medication that you are currently taking. Include any over the counter medications, vitamin, mineral and herb supplements.

Medication	Dosage	Frequency

SOCIAL HISTORY

Patient lives with: ☐ Father ☐ Mother ☐ Other Adopted: ☐ Yes ☐ No

Grade in school:_____ # of Brothers: _____ # of Sisters: _____

If over 14: Do you use alcohol? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Menstrual History (females over 10)

Have you started menstruation? ☐ Yes ☐ No If yes, what age? _____

Is there a possibility that you might be pregnant? ☐ Yes ☐ No

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FAMILY HISTORY

Please check all that apply to your extended and immediate family history conditions:

Blood Clots	☐	Cancer	☐	Neurologic Disease	☐	Sudden Death	☐
Diabetes	☐	Heart disease	☐	Scoliosis	☐	Marfan's Syndrome	☐
Hypertension	☐	Osteoporosis/Arthritis	☐	Bone Cancer	☐	Long QT Syndrome	☐
Rheumatoid Arthritis	☐	Stroke	☐	Hip Dysplasia	☐	Other _____	☐
Anesthetic Problems	☐	Benign Bone Tumors	☐	Seizures	☐		

REVIEW OF SYMPTOMS

1. GENERAL	☐ None	☐ Weight Gain	☐ Weight Loss	☐ Chills
	☐ Fever	☐ Weakness/Fatigue	☐ Other _____	
2. EYES	☐ None	☐ Blurred Vision	☐ Glasses	☐ Contacts
	☐ Eye Pain	☐ Redness	☐ Other _____	
3. EARS, NOSE, THROAT	☐ None	☐ Nose Bleeds	☐ Earache/Infection	☐ Hoarseness
	☐ Ringing in ear		☐ Other _____	
4. CARDIOVASCULAR	☐ None	☐ Chest Pain	☐ Swelling in legs	☐ Palpitations
	☐ Shortness of breath		☐ Other _____	
5. RESPIRATORY	☐ None	☐ Wheezing/Asthma	☐ Frequent Cough	
			☐ Other _____	
6. GASTROINTESTINAL	☐ None	☐ Heartburn	☐ Vomiting	☐ Nausea
	☐ Abdominal Pain		☐ Other _____	
7. MUSCULOSKELETAL	☐ None	☐ Stiffness	☐ Muscle aches	☐ Instability
	☐ Swelling of Joints		☐ Other _____	
8. SKIN	☐ None	☐ Rash	☐ Itching	☐ Redness
	☐ Keloid Scars	☐ Psoriasis	☐ Other _____	
9 NEUROLOGICAL	☐ None	☐ Headaches	☐ Numbness/Tingling	☐ Fainting spells
	☐ Loss of sensation in any part of body		☐ Dizziness	☐ Poor balance
	☐ Seizures		☐ Other _____	
10. PSYCHIATRIC	☐ None	☐ Depression	☐ Nervousness	☐ Anxiety
			☐ Other _____	
11. ENDOCRINE	☐ None	☐ Excessive thirst/hunger	☐ Hot/cold intolerance	☐ Hot Flashes
			☐ Other _____	
12. HEMATOLOGICAL	☐ None	☐ Easy bruises	☐ Easy Bleeding	☐ Varicose Veins
	☐ Blood clots		☐ Other _____	

Name of Patient; (print): _____

Signature (responsible party if under 18): _____ Date:_____ Time:_____

PRINT SAVE AS RESET

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For in-clinic use only

Temp	HR	RR	B/P	Wt (kg)	Ht (cm)	HC	O2 Sat

Pain Score	Pain Scale

Staff Signature: _____ Date:_____ Time:_____