William P. Zink, M.D.

2909 North Orange Ave, Suite 102
Orlando, Florida 32804
(407) 894-0088 Tel (407) 895-6790 Fax

Date: ___________

Patient Name: (First) ________________ (Middle) ____________ (Last)

DOB: ___/___/_____ SSN: ____-___-______

Address: ____ HomePh: ___________

City/State/Zip: ________________ ____________ Cell Ph: ___________

Father: (Name) ______________________ (Occupation) ___________

Employed by: ______________________ Ph ___________

Employer Address: ______________________

Mother: (Name) ______________________ (Occupation) ___________

Employed by: ______________________ Ph ___________

Employer Address: ______________________

Emergency Contact: ______________________ Ph ___________

Relative/Friend: ______________________

(name and address of close friend or relative who will know where you are in 5+ years from now for follow-up study)

Pharmacy Name: ______________________ Ph ___________

Address: ______________________

#1 Medical Insurance: ______________________

Insured's Name: ______________________ DOB ___________

Group or Employer Name: ______________________

Policy #: ______________

Claims Address/Phone ______________________

#2 Medical Insurance: ______________________

Insured's Name: ______________________ DOB ___________

Group or Employer Name: ______________________

Policy #: ______________

Claims Address/Phone ______________________

Chief Complaint: ______________________ How Long: ________

Date of Incident: ____________ How did it happen? ______________________

____

Place of Incident: ______________________

Prior Treatment for this Complaint: When? __________ Where? ______________

By whom? ______________________

Prior X-Rays ? Where ______________ When? ______________

Referred By: ______________________

Address: ______________________

Pediatrician or Family Doctor: ______________________

I Hereby Authorize William P. Zink, M.D. to release any information acquired in the course of my treatment to:

____

Date: ____________ Signature: ______________________

I authorize, assign and direct you to pay without further notice from me to William P. Zink, M.D. such amount as may be payable to me for medical and/or surgical treatment.

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PEDIATRIC ORTHOPAEDICS ADOLESCENT SPORTS MEDICINE

CHILDS MEDICAL HISTORY

Date ____________

Name ____________ Birthdate ____________ Sex ______ Race ______ County ______

MATERNAL AND NEONATAL HISTORY

This child was pregnancy Number ______
Mother's Prenatal Care:
Private M.D. ☐ None ☐
Other ______
Length of Pregnancy ______

Prenatal complications: None ☐
Toxemia ☐ Hemorrhage ☐ Anemia ☐
Rubella ☐ Syphilis ☐ Other ☐
Drugs Taken During Pregnancy ______
______ Vitamin ☐ Iron ☐
Other ______

Delivery In: Hospital ☐ Home ☐
Other ______
Name of Hospital ______

Type Delivery: Normal ☐ C Section ☐
Abnormal (Explain) ______

Was the child breach? Yes ☐ No ☐
Length of Labor ______
Newborn:
Birth Weight ______ lbs. ______ ozs.
APGAR ______ / ______

Complications: None ☐
Difficult Resuscitation ☐ Meconium ☐
Convulsions ☐ Injury ☐
Jaundice ☐ Other ______

Previous Xrays
Where done ______
What was Xrayed ______

When ______

DEVELOPMENTAL HISTORY

	AGE
Sat Alone	______
Stand	______
Speech	______
Toilet Trained	______

Did Child's Development Seem
Normal ☐ - Slow ☐

Allergies: None ☐
______

Medications: None ☐
______

Braces, Orthotic or Orthopaedic Shoes
______

Operations: None ☐
______

Hospitalizations: None ☐
______

FAMILY HISTORY

Brothers & Sisters of Patient

	Name	Age	Sex
1.			
2.			
3.			
4.			
5.			

In child's parents or sibling are any of these health problems present:

	Yes	No
Club Foot	☐	☐
Hip Defects	☐	☐
Cancer	☐	☐
Scoliosis	☐	☐
Frequent Fractures	☐	☐
Bleeding Problems	☐	☐
Other Birth Defects	☐	☐
Heart Trouble	☐	☐
Seizures	☐	☐
Diabetes	☐	☐
Mental Illness	☐	☐
Neurological Disease	☐	☐
Tuberculosis	☐	☐

Explain all Yes answers
______

HEALTH HISTORY OF THE PATIENT

	Yes	No
Headaches	☐	☐
Nosebleeds	☐	☐
Eyeglasses	☐	☐
Frequent earaches	☐	☐
Hearing problems	☐	☐
Frequent colds	☐	☐
Bronchitis	☐	☐
Pneumonia	☐	☐
Whooping cough	☐	☐
Diphtheria	☐	☐
Fainting spells	☐	☐
Shortness of breath	☐	☐
Heart problems	☐	☐
Scarlet fever	☐	☐
Frequent diarrhea	☐	☐
Constipation	☐	☐
Vomiting	☐	☐
Jaundice	☐	☐
Bed wetting	☐	☐
Unexplained fevers	☐	☐
Bladder problems	☐	☐
Kidney problems	☐	☐
Seizures	☐	☐
Behavior problems	☐	☐
Frequent accidents	☐	☐
Anemia	☐	☐
Bleeding tendency	☐	☐
Chicken Pox	☐	☐
Loss of consciousness	☐	☐
Frequent fractures	☐	☐

SPORT PARTICIPATION

1st Sport ______
Other Sport ______
Previous Sport Injury ______

SOCIAL HISTORY

School Level ______
School Attending ______
Are both parents living at home?
☐ Yes ☐ No