

Orthopaedic and Hand Specialists, P.A.

Date: _____ Chart # _____ Provider _____

Patient Name (Please Print) _____

BP _____ / _____ Pulse _____

Patient Signature _____

Temp _____ H _____ W _____

Age _____ F M Height _____ Weight _____ Did you bring x-rays? Y N

Who requested that you visit this office? Doctor _____ Self-Referral Attorney _____

What is the main reason for this visit? Pain Numbness Weakness Other _____ (Chief Complaint)

What body part is involved?							(Location)
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L	
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L	

How long has this problem been present? _____ Days Weeks Months

Check the box which best fits how your problem started. Then answer the one question below the box you checked.

Use as much space to the right as needed.

NO INJURY (Onset was: Gradual or Sudden)

ANSWER:

?Why do you think it started?

INJURY - (NOT AUTO OR WORK)

Date _____, Where and how did it happen?

INJURY AT WORK

Date _____, Where and how did it happen?

WORK RELATED - (BUT NO INJURY)

Date _____, How did your job cause this problem?

AUTO ACCIDENT

Date _____, Where and how was your car hit?

Please check the box below which best describes your problem:

The pain is Constant Comes and goes (intermittent) (Duration)

Severity of pain Mild Moderate Severe Extremely severe (Severity)

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning Other _____ (Quality)

Are there associated symptoms? Swelling Numbness Weakness (Assoc Symp)

Since my problem started, it is: Getting better Getting worse Unchanged (Context)

Does your pain wake you from sleep? Yes No (Timing)

What makes your symptoms worse? Activity Exercise Work Other _____ (Modify)

Which makes you feel better? Rest Heat Ice Elevation Other _____ (Modify)

What medication have you taken or been prescribed for this problem? _____ (Modify)

Check which treatments you have tried: Injection Y N; Brace Y N; Therapy Y N (Modify)

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

1) M/S >Have you had a prior problem with this same Orthopaedic condition in the past? Y N (explain below)

>Have you had prior Back pain Joint swelling Prior Fracture Arthritis _____

2) ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N If yes, please list _____

3) ARE YOU A DIABETIC? Y N Treatment: Insulin Oral Meds Diet None

(Please check any that apply, or mark NONE)	None	Year	Explain Details/Comments
4) CON <input type="checkbox"/> weight loss <input type="checkbox"/> loss of appetite <input type="checkbox"/> fever <input type="checkbox"/> cancer	<input type="checkbox"/>	_____	_____
5) EYE <input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> double vision <input type="checkbox"/> cataract	<input type="checkbox"/>	_____	_____
6) ENT <input type="checkbox"/> hearing loss <input type="checkbox"/> hoarseness <input type="checkbox"/> ringing in ears	<input type="checkbox"/>	_____	_____
7) CV <input type="checkbox"/> high blood pressure <input type="checkbox"/> heart attack <input type="checkbox"/> blood clots	<input type="checkbox"/>	_____	_____
8) RS <input type="checkbox"/> asthma <input type="checkbox"/> cough <input type="checkbox"/> pneumonia <input type="checkbox"/> short of breath <input type="checkbox"/> TB	<input type="checkbox"/>	_____	_____
9) GI <input type="checkbox"/> stomach ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Blood in stool	<input type="checkbox"/>	_____	_____
10) GU <input type="checkbox"/> Pain with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney disease	<input type="checkbox"/>	_____	_____
11) SK <input type="checkbox"/> Skin ulcers <input type="checkbox"/> Rash <input type="checkbox"/> Lumps	<input type="checkbox"/>	_____	_____
12) NEU <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Balance problem <input type="checkbox"/> Headaches	<input type="checkbox"/>	_____	_____
13) PSY <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Sleep disorder	<input type="checkbox"/>	_____	_____
14) HEM <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia	<input type="checkbox"/>	_____	_____

PAST MEDICAL HISTORY

WHAT MEDICATIONS DO YOU TAKE? None Please list with dosage: _____

ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BLOOD THINNERS? Y N If yes, _____

PAST HOSPITALIZATIONS (Not for surgery) None _____

PAST SURGICAL HISTORY: What operations have you had? When? None _____

Have you ever had a reaction to anesthesia? Y N

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relatives?

Any direct relative with the same Orthopaedic condition you are being seen for today? Y N _____

Diabetes: Y N _____

High Blood Pressure: Y N _____

Heart disease: Y N _____

Arthritis: Y N _____

SOCIAL HISTORY:

Do you use tobacco products? Y N Packs per day _____

Alcohol use? Y N How often? Daily Other _____/week

Marital History: M S D W How many people live with you? _____

Occupation: _____ Student

Are you currently working? Y N If no, how long have you been out of work? _____

FOR OFFICE USE ONLY

Reviewed for completeness by _____ Date ____/____/____

Reviewed by MD _____ Date ____/____/____