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 ☐	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
Back ☐ Mid ☐ Lower	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe ☐ R ☐ 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** ☐weight loss ☐loss of appetite ☐fever ☐cancer	☐	_____	_____
5) **EYE** ☐glasses ☐contacts ☐double vision ☐cataract	☐	_____	_____
6) **ENT** ☐hearing loss ☐hoarseness ☐ringing in ears	☐	_____	_____
7) **CV** ☐high blood pressure ☐heart attack ☐blood clots	☐	_____	_____
8) **RS** ☐asthma ☐cough ☐pneumonia ☐short of breath ☐TB	☐	_____	_____
9) **GI** ☐stomach ulcer ☐Hepatitis ☐Blood in stool	☐	_____	_____
10) **GU** ☐Pain with urination ☐Blood in urine ☐Kidney disease	☐	_____	_____
11) **SK** ☐Skin ulcers ☐Rash ☐Lumps	☐	_____	_____
12) **NEU** ☐Seizures ☐Stroke ☐Balance problem ☐Headaches	☐	_____	_____
13) **PSY** ☐Depression ☐Nervousness ☐Sleep disorder	☐	_____	_____
14) **HEM** ☐Easy bleeding ☐Easy bruising ☐Anemia	☐	_____	_____

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____/___/_____