

ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

PLEASE COMPLETE ALL INFORMATION

Today's Date: _____ Physician Seeing Today: _____

Name: _____

Sex: Male Female Age: _____ DOB: _____ Height: _____ Weight: _____

Marital Status: Single Married Divorced Widowed Occupation: _____ Student: Yes No

Referred By: _____ Primary Care Doctor: _____

CHIEF COMPLAINT: Explain why you are here to see the doctor(specify right or left) _____

Was this the result of an accident or injury? YES NO UNKNOWN Is this a work related injury? YES NO

What was the date of injury (if unknown, approximately how long have you had symptoms)? _____

Where/how did the injury occur? _____

Have you seen another Doctor, Hospital or any other medical personnel for this problem? YES NO

Name of person/facility treating you: _____

Date of treatment: _____

Have you had any of the following for this problem? Please list date.

X-rays: _____ MRI: _____ CT: _____

Myelogram: _____ EMG: _____ Other (be specific): _____

Have you had any of the following for your symptoms? If so, list date and type of treatments.

Surgery: _____

Physical therapy (# of treatments and body part): _____

Injections (body part and date): _____ Medication: _____

Please circle if applicable: brace splint cast walker crutches wheelchair

How does this condition affect you?

- Wakes you at night
- Interferes with work activities
- Interferes with recreational activities

HOW SEVERE IS YOUR PAIN?

1 2 3 4 5 6 7 8 9 10

mild moderate severe

MEDICATIONS (LIST ALL CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER DRUGS AND DIET SUPPLEMENTS):

ALLERGIES (LIST ALL DRUG AND FOOD ALLERGIES): _____

FAMILY HISTORY: Please Check **ALL** That Apply

- Arthritis
- Cancer
- Diabetes Type I Type II
- Heart Disease

SOCIAL HISTORY

Do you smoke? YES NO Drink alcohol? Daily Weekly Occasionally Never

MEDICAL HISTORY: please check ALL that apply to you

CARDIOVASCULAR <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Blood clot Where: _____ <input type="checkbox"/> Chest pain <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Pacemaker <input type="checkbox"/> Palpitations <input type="checkbox"/> Stent RESPIRATORY <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Sleep Apnea	GASTROINTESTINAL <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Crohns Disease <input type="checkbox"/> Ulcer: list type _____ HEPATIC <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis A B C <input type="checkbox"/> Jaundice <input type="checkbox"/> Pancreatitis INFECTIOUS DISEASE <input type="checkbox"/> HIV <input type="checkbox"/> MRSA <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other _____ RENAL <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Urinary tract infection	NEUROLOGIC <input type="checkbox"/> ADHD <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Diabetic Neuropathy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Polio <input type="checkbox"/> Seizure <input type="checkbox"/> Stroke <input type="checkbox"/> TIA ENDOCRINE <input type="checkbox"/> Adrenal Abnormality <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo CANCER <input type="checkbox"/> List Type: _____	MUSCULOSKELETAL <input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gout <input type="checkbox"/> Lupus <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other _____ PSYCHIATRIC _____ _____ _____ _____ OTHER _____ _____ _____ _____ _____
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PAST SURGICAL HISTORY: List ALL surgeries: body part, including side (right or left) and approximate date

REVIEW OF CURRENT SYMPTOMS: Please check ALL that apply.

GENERAL <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fever Chills HEAD/NECK <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Sore throat <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Loss of hearing CARDIOVASCULAR <input type="checkbox"/> Chest pain <input type="checkbox"/> Skipped heart beats	NEUROLOGIC <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness/Tingling: location _____ <input type="checkbox"/> Weakness <input type="checkbox"/> Headaches SKIN <input type="checkbox"/> Unusual rashes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Infection	RESPIRATORY <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing GASTROINTESTINAL <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody stools <input type="checkbox"/> Indigestion	GENITOURINARY <input type="checkbox"/> Pain with urination <input type="checkbox"/> Unable to urinate <input type="checkbox"/> Involuntary urination MUSCULOSKELETAL <input type="checkbox"/> Joint swelling <input type="checkbox"/> Morning stiffness <input type="checkbox"/> Joint pain
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I certify, to the best of my knowledge, all information listed above is true. I further certify that I have not misstated or intentionally omitted any information related to my health or past medial history.

Date: _____

SIGNATURE of patient/guardian: _____