Center for Orthopaedic Surgery and Sports Medicine

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Patient's Name: _____ Today's date: _____

Age: _____ Height: ____' ____" Weight: _____lbs Sex: M F Who referred you to this office? _____

Which is your dominant hand? ☐ Right ☐ Left

What is the main reason for this visit?
☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness

☐ Other _____

Which body part is involved (circle which side)**?**

Shoulder R / L Elbow R / L Arm R / L Wrist R / L Hand R / L

Fingers R / L Hip R / L Knee R / L Ankle R / L

Please check one below that best describes how the problem started:

☐ No injury, Onset was GRADUAL / SUDDEN (circle one)

How or why do you think it started: _____
_____

☐ Injury, ACCIDENT / SPORTS RELATED (circle one)

Date of injury: _____/_____/_____

Where and How did it happen? _____
_____
_____

On a scale of 0 through 10 (10 being the worst), **how severe is your pain?**

0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain?

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

☐ Other _____

Is the pain:

☐ Constant ☐ Intermittent ☐ Wakes me from sleep

☐ Other _____

Are you currently under the care of a pain management physician?

☐ Yes ☐ No Date care started: _____/_____/_____

Physicians name if yes: _____

List Medications prescribed by this physician: _____
_____

Is there any chance you could be pregnant? ☐ Yes ☐ No ☐ NA

Do You Have:
☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness
☐ Bruising ☐ Other _____

Since your problem began, is it:
☐ Getting Better ☐ Gotten Worse ☐ Unchanged
☐ Other_____

What makes your problem worse?
☐ Sitting ☐ Standing ☐ Lifting ☐ Walking ☐ Bending
☐ Kneeling ☐ Squatting ☐ Twisting ☐ Stairs ☐ Exercise
☐ Coughing/ Sneezing ☐ Lying in bed ☐ Grabbing ☐ Grasping
☐ Pushing ☐ Pulling ☐ Other _____

What makes your symptoms better?
☐ Rest ☐ Ice ☐ Heat ☐ Other_____

What medication are you taking now/previously for this problem?

_____

Have you had any of these treatments for this problem?
☐ Injection ☐ Brace ☐ Cane/Crutches
☐ Other_____

Have you had any Physical Therapy? ☐ Yes ☐ No
If so, Where _____

Date(s): TO: _____/_____/_____ FROM: _____/_____/_____

Were you seen in the ER for this problem? ☐ Yes ☐ No

Where? _____ Date(s): _____/_____/_____

What tests/scans have you had for this problem in the past year?

☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ _____
Did you bring X-rays or a MRI disc today ☐ Yes ☐ No

Have you had surgery for a problem in this same area recently or or in the past? ☐ Yes (please list below) ☐ No

Procedure: _____

Surgeon: _____

City: _____ **Date:** _____/_____/_____

Procedure: _____

Surgeon: _____

City: _____**Date:** _____/_____/_____

Do you have ALLERGIES to any medications? ☐ Yes ☐ No
Which Medications: _____
_____
_____

List Current Medication you take with dosage:
_____
_____
_____
_____
_____

Review of systems: (check any conditions below that you have):

System	Condition
MS	☐ Osteoporosis ☐ Gout ☐ Fracture ☐ Back Pain ☐ Arthritis ☐ Rheumatoid Arthritis
GI	☐ Heartburn ☐ Ulcers/Bleeding ☐ Nausea ☐ Vomiting ☐ Acid Reflux ☐ Blood in Stool ☐ Loss of Bowel Control
ENDO	☐ Frequent Thirst ☐ Frequent Urination ☐ Hot or Cold
CONST	☐ Weight Loss ☐ Frequent Fever ☐ Loss of Appetite
EYE	☐ Blurred Vision ☐ Double Vision ☐ Vision Loss
ENT	☐ Hearing Loss ☐ Hoarseness ☐ Trouble Swallowing
CV	☐ Chest Pain ☐ Palpitations ☐ Heart Failure ☐ Pacemaker ☐ High Blood Pressure ☐ Heart Attack (year)____/____/____
RESP	☐ Chronic Cough ☐ Shortness of Breath ☐ COPD ☐ Asthma
GU	☐ Frequent Urination ☐ Kidney Problems/Failure ☐ Dialysis ☐ Loss of Bladder Control ☐ Blood In Urine
SKIN	☐ Frequent Rashes ☐ Skin Ulcers ☐ Psoriasis/ Eczema
NEURO	☐ Headaches ☐ Dizziness ☐ Seizures ☐ Stroke
PSYCH	☐ Depression ☐ Sleep Disorder ☐ Drug/Alcohol Problems
HEME	☐ Bleed Easily ☐ HIV/AIDS ☐ Hemophilia ☐ Aspirin Sensitivity

CANCER ☐ Yes ☐ No Where: _____

DIABETIC ☐ Yes ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

HEPATITIS ☐ Yes ☐ No Type: _____

LIVER DISEASE ☐ Yes ☐ No

History of blood clots that you had to take blood thinner to treat? ☐ Yes ☐ No

OTHER: _____
_____

Family History: Have any direct relatives had any of the following?

☐ Hemophillia Relative:_____
☐ High Blood Pressure Relative:_____
☐ Diabetes Relative:_____
☐ Rheumatoid Arthritis Relative:_____

Past Surgical History – List all operations below:
_____
_____
_____
_____

Have you ever had a reaction to anesthesia? ☐ Yes ☐ No

Describe: _____

Do you use tobacco? ☐ Yes **Packs per day** _____
☐ Previous Smoker Year Quit: _____
☐ Never Smoked

What is your alcohol use? ☐ None ☐ Social ☐ Daily

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ **Student?** ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ America Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/Other Pacific Islander
☐ White

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

EMAIL ADDRESS: _____
(E-mail used for patient portal)

PREFERRED PHARMACY:

_____

Location: _____

Phone Number: _____

THE INFORMATION ON THIS FORM IS ACCURATE AND TO THE BEST OF MY KNOWLEDGE.

_____
PATIENT SIGNATURE

_____/_____/_____ **DATE**

**** Please note: We do not generally prescribe pain medication for long term use. All pain medications are closely monitored and prescribed on an "as needed " basis.**