Name:_____DOB_____

MRN:_____ DATE_____

Age:_____Height:_____Weight:_____ Do you write:❑*RIGHT* or ❑*LEFT* handed

Occupation:_____Work status: ❑Full ❑Light ❑Unable ❑School ❑Retired ❑None

Primary Care Provider:_____Cardiologist:_____

Your Pharmacy: _____Pharmacy Address: _____

How did you hear about us?

Chief Complaint (REASON YOU ARE HERE TODAY):

_____

TODAY I'd like (check all applicable)
❑Info ❑Xrays ❑Therapy
❑Med Refill ❑Injection ❑Surgery

Date of Injury: _____ How long have you had the problem? _____

Where did it occur? ❑AUTO ❑WORK ❑SCHOOL ❑HOME ❑OTHER_____

Were YOU Treated in the ER? ❑NO ❑YES(Hospital?)_____ DATE_____

Did you have: ❑X-Rays ❑MRI ❑NCV/EMG ❑Myelogram ❑Bone Scan ❑CT Scan

For THIS problem have you tried: ❑Therapy ❑Medicine ❑Cream ❑Injection

What makes it better? Worse?

This problem is: ❑Constant ❑Daily ❑Waking at night ❑Improving ❑Worsening

Have you been treated by another ORTHOPAEDIC physician for this problem? ❑NO

❑YES(doctor/surgery/treatment):

MARK ALL AFFECTED AREAS WITH APPROPRIATE "SENSATION SYMBOL" WHERE YOU FEEL THESE DESCRIBED SENSATIONS. MARK THE POINT OF MAXIMUM PAIN WITH LARGE "X"

Sensation Symbols:

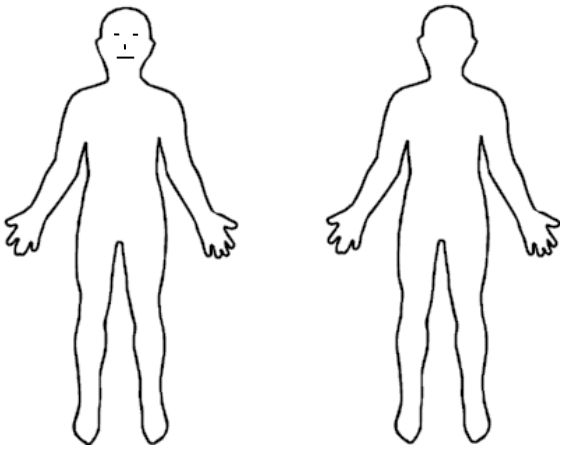
Ache : ^^^
^^^

Burning : x x x x
x x x x

Numbness : oooo
oooo

Pins & Needles: = = = =
= = = =

Stabbing : ////
////



Pain at rest: 0 1 2 3 4 5 6 7 8 9 10 (worst)
Pain with activity: 0 1 2 3 4 5 6 7 8 9 10 (worst)

CURRENT MEDICATIONS: ❑ None

❑NO CHANGE FROM LAST VISIT (ONLY FOR FOLLOW UP)

❑ Check if submitting an up-to-date copy of medications

NAME OF DRUG - DOSAGE - HOW OFTEN TAKEN

1._____
2._____
3._____
4._____
5._____
6._____

Are you taking: ❑Gingko ❑Phentermine
BLOOD THINNERS? ❑No ❑Yes_____
SUPPLIMENTS? ❑No ❑Yes_____

Provider Signature/Date:

MEDICAL HISTORY ❑None

❑NO CHANGE FROM LAST VISIT (follow up)

❑Hypertension ❑High Cholesterol
❑Diabetes ❑Hypothyroid
❑Hyperthyroid ❑Reflux / Ulcer
❑Fibromyalgia ❑COPD / Emphysema
❑Heart Attack ❑Stroke ❑Blood clot
❑Cancer _____

1._____
2._____
3._____
4._____
5._____
6._____
7._____

SOCIAL HISTORY

❑No change (FOLLOW UP patient only)

In past year have you:
Fallen >1x ❑No ❑Yes
Fracture from fall? ❑No ❑Yes

Date of last flu vaccine_____❑None

Cigarette Smoker?❑Never ❑Former ❑Yes
years _____
packs/day _____
❑E-cig ❑Vape ❑Chew ❑Cigar # years___

Alcohol ❑Daily ❑Weekly ❑Monthly ❑No

PAST SURGERIES ❑None

❑Pacemaker ❑ CABG ❑Total hip R / L
❑Total knee R / L ❑Carpal Tunnel R / L
❑Cubital tunnel R / L ❑Cervical fusion
❑Lumbar fusion ❑ Kypho ❑ Lami
❑Cancer removal_____

1._____
2._____
3._____
4._____
5._____

FAMILY HISTORY

Draw LINE from family member to issue if applicable

Liver	Grandma	Heart disease
Thyroid	Grandpa	High cholesterol
Diabetes	Mom	Kidney
Stroke	Dad	Hypertension
Dementia	Brother	Rheumatologic
Rheum	Sister	Cancer
Anemia	Children	I do not know

REVIEW OF SYSTEMS (CHECK if applicable)

Cancer❑_____
Fever❑ ❑ Shoulder stiffness
Nausea/Vomit❑ ❑ Multiple joint swelling
Heartburn❑ ❑ Weakness
Short of Breath❑ ❑ Loose joints
Snoring❑ ❑Tremors
CPAP❑ ❑ HIV / AIDS
Chest Pain❑ ❑ Hepatitis
Rash❑ ❑ MRSA
Swollen glands❑ ❑ International travel
Easy Bruising❑ ❑ Schizophrenia
Loose teeth❑ ❑Dentures
Hard to hear❑ ❑Bowel / bladder issues
❑I have no symptom listed above

DRUG ALLERGIES: ❑No (List drug and reaction)

1_____
2_____
3_____
4_____

FOOD ALLERGY: ❑No ❑Yes_____
METAL ALLERGY: ❑No ❑Yes_____