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Orthopaedic & Sports Medicine
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Patient Name: _____ Today's Date: _____

Age: _____ Referring Physician: _____ Family Physician: _____

What is the main reason for your visit today? (Check all that apply)

❒ Back Pain ❒ Leg Pain ❒ Neck Pain ❒ Arm Pain

❒ Other: _____

How long has this been a problem?

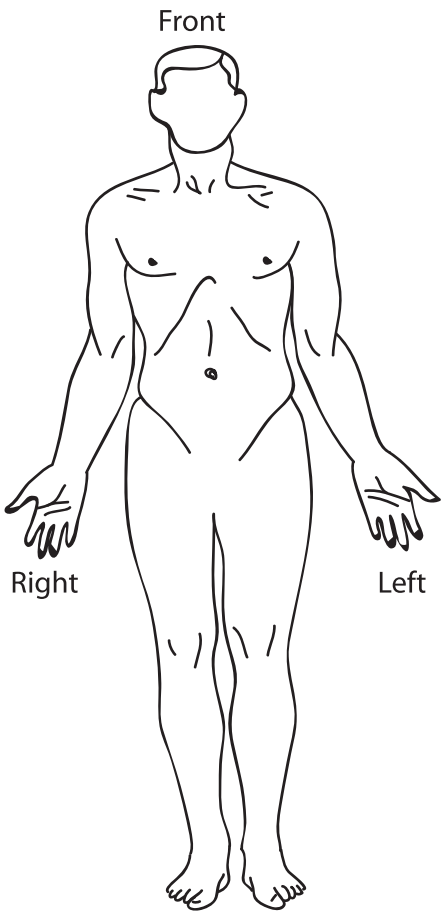
❒ Less than 2 Months ❒ 2-6 Months ❒ 6-12 Months ❒ Greater than 1 year

❒ Further Comments: _____

Are your symptoms the result of an accident? ❒ Yes ❒ No

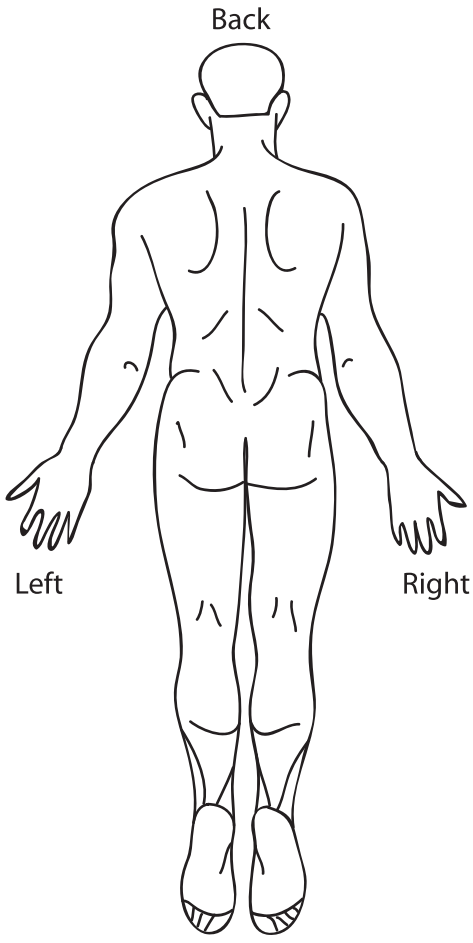
If so, where did the accident occur? ❒ Work ❒ Home ❒ Auto ❒ Other _____

WHERE IS YOUR PAIN NOW?



Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	100	%

Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, neck and back.



Use the body diagrams to show where you feel the following sensations.

Ache	Numbness	Burning	Stabbing
AAA	000	XXX	/ / /
AAA	000	XXX	/ / /
AAA	000	XXX	/ / /

Please mark the scale below with an X to rate your current pain level.

0 ——— 1 ——— 2 ——— 3 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

What makes your pain worse? (Check all that apply)

❒ Sitting ❒ Lying Down ❒ Coughing ❒ Bending ❒ Standing
❒ Sneezing ❒ Lifting ❒ Walking ❒ Leaning Forward
❒ Other: _____

Is your pain?

❒ 0 - 4 hours per day ❒ 4 - 8 hours per day ❒ > 8 hours per day ❒ Constant

What makes your pain better? (Check all that apply)

❒ Sitting ❒ Lying Down ❒ Bending ❒ Standing ❒ Walking
❒ Knee to chest ❒ Aspirin ❒ Tylenol ❒ Ibuprofen ❒ Aleve
❒ Other: _____

Is your pain associated with any of the following?

Numbness ❒ Yes ❒ No If so, where? _____
Tingling ❒ Yes ❒ No If so, where? _____
Weakness ❒ Yes ❒ No If so, where? _____
New difficulty controlling bowels ❒ Yes ❒ No
New difficulty controlling bladder ❒ Yes ❒ No

What treatments have you had for this problem? (Check all that apply)

❒ None ❒ Physical Therapy ❒ Chiropractic ❒ Injections ❒ Pool Therapy
❒ Strengthening ❒ Traction ❒ Acupuncture ❒ TENS ❒ Massage
❒ Brace ❒ Heat/Ice ❒ Therapeutic Ball ❒ Muscle Relaxants ❒ Pain Medications
❒ Anti-Inflammatory (Prescription) ❒ Anti-Inflammatory Over the Counter (Aspirin, Tylenol, Advil, Aleve, etc.)
❒ Other: _____

Have you had any tests for this problem?

❒ X-Ray ❒ MRI ❒ Discography ❒ CT ❒ EMG
❒ CT/Myelogram ❒ Bone Scan ❒ Other (Please Specify): _____

Is there any family history of back pain? ❒ Yes ❒ No

Are you able to work? ❒ Yes ❒ No

Please describe your job: _____

Are you on disability? ❒ Yes ❒ No

Do you have an attorney helping you due to this injury? ❒ Yes ❒ No

Have you been treated by any other Care Giver for this condition? ❒ Yes ❒ No

If yes, please list: _____

PAST SURGICAL HISTORY AND / OR HOSPITALIZATION

Previous: Type of Operations or reason for Hospitalization	Year
1	
2	
3	
4	

Any previous fractures? ❒ Yes ❒ No
Any other serious injuries? ❒ Yes ❒ No

MEDICATION INFORMATION

Drug Allergies: Do you have any drug allergies? ❒ Yes ❒ No Latex allergy? ❒ Yes ❒ No

If yes name the drug and the type of reaction. (ex. rash, nausea, etc.) PLEASE BE SPECIFIC.

Current Meds: (List any medications you are taking at this time. Includes such items as aspirin, vitamins, laxatives, calcium, etc.)

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Please Check: Helped?		
			A lot	Some	Not At All
1					
2					
3					
4					
5					
6					

MEDICAL HISTORY / REVIEW OF SYSTEMS

Please check if you have had a history of any of the following:	YES	NO		YES	NO
GENERAL			**CARDIOVASCULAR**		
Are you currently pregnant?			Chest pain, Angina		
Diabetes			Heart Attack, Myocardial Infarction		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure, Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Ankle Swelling		
Cancer TYPE:			**HEMATOLOGIC**		
Fatigue			Anemia		
Weakness			Blood Clots		
Fevers			Bleeding Tendency		
Skin Problems / disorders TYPE:			Easily bruised		
Rheumatic Fever			Circulatory problems		
Tuberculosis			Blood thinners (currently on)		
Recent weight loss/gain. How Much?			(if yes, type: _____)		
BLOODBORNE PATHOGENS			Phlebitis		
HIV / AIDS			**MUSCULOSKELETAL**		
Hepititis			Joint Pain		
Other			Joint Swelling		
SITES OF INFECTION			Muscle weakness		
Urinary			Muscle tenderness		
Dental			Morning Stiffness		
Other			Arthritis / Osteoarthritis		
NEUROLOGICAL			Rheumatoid Arthritis		
Headaches			Bunions		
Dizziness			Osteoporosis		
Fainting			Previous bone density test?		
Memory Loss			Bone / Joint infections		
Loss of consciousness			Gout		
Muscle spasms			**PSYCHOLOGICAL**		
Numbness or tingling of hands/feet			Depression		
Blindness or trouble seeing			Anxiety disorder		
Deafness or trouble hearing			Other		
Seizures					

Other illnesses or diseases which are not listed? Please describe.

_____

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Abnormal bleeding tendencies		
Heart Disease			Rheumatoid Arthritis		
Anesthetic complications			Osteoarthritis		
Cancer TYPE:			Gout		

SOCIAL HISTORY

What is your approximate weight? _____ Lbs. Height: _____ Ft. _____ Shoe size: _____ BMI (doctor use)

Occupation: _____ No. of years: _____ Job Duties: _____

Do you smoke? ☐ Yes ☐ No ☐ Past If Yes or Past, _____ packs per day for _____ years

Are you ☐ Right Handed ☐ Left Handed

Do you consume alcohol? If so, how many drinks per week? _____ Is there history of abuse? ☐ Yes ☐ No

Have you ever had a problem with drugs? ☐ Yes ☐ No

Do you participate in recreational drugs? ☐ Yes ☐ No

Do you regularly wear your seat belt? ☐ Yes ☐ No

Please list all sports and hobbies your are involved in:

What is your principal support system? Example: Spouse, Family, Friends, Church

I, as the patient, state the information is correct and accurate to the best of my knowledge. ***Patient Signature:*** _____ ***Date:*** _____

I have reviewed this information with this patient.

M.D. Signature: _____ ***Date:*** _____