TOC The Orthopaedic Center

Today's Date ___________________

Patient's Legal Name ______________________________________
Last First Middle

Age _____ Date of Birth ________________ Male ☐ Female ☐ Occupation ________________________________

Referred by ____ Family Physician ___________________________________

PLEASE COMPLETE ALL AREAS INSIDE THIS BOX:

1) Was this an accident: ☐ Yes If an accident what Date: ___________________________ ☐ No (if no, go to #3)
2) If an accident, please explain how it happened: ____
____
3) If not an accident, when was the onset of today's condition: ____
____
4) Specific location of injury or pain: Right _________ Left _________ Location_________________________
5) Is pain sharp / dull, constant / occasional?____
6) What are your symptoms? ____
____
7) On a scale of 1 to 10, 10 being the worst, what is the severity of your pain? _____________________________
8) What activities make the problem feel worse? ____
or better? ____
9) How long have you experienced this problem? ____
10) If you have had an X-ray, MRI, PT or Injections in the last 60 days for this problem, please list those here: ____

List all medications that you are currently taking (prescription and non-prescription): ☐ See attached medication list

Medication Name	Dosage	Times/Day	Medication Name	Dosage	Times/Day

ARE YOU ALLERGIC TO ANY MEDICATIONS?: ☐ Yes ☐ No **Latex Allergy?:** ☐ Yes ☐ No

List any medications that you are allergic to and the reaction it causes:

____
____
____

ARE YOU OR HAVE YOU BEEN UNDER CARE OF A PAIN CLINIC? ☐ Yes ☐ No

DO YOU HAVE A HISTORY OF BLOOD CLOTS OR DVT? ☐ Yes ☐ No

Prior Surgeries: ____
____

ROS

Please check all CURRENT positive findings that apply to you or mark none.

CONSTITUTIONAL	☐ weight loss	☐ weight gain	☐ loss of appetite	☐ weakness		☐ NONE
EENT	☐ blurry vision	☐ hoarseness	☐ ringing in ears			☐ NONE
CARDIAC	☐ chest pain	☐ irregular heartbeat	☐ swelling in the legs or feet			☐ NONE
RESPIRATORY	☐ pain when breathing	☐ shortness of breath				☐ NONE
GASTROINTESTINAL	☐ liver problems	☐ blood in stool	☐ gallbladder problems			☐ NONE
GENITOURINARY	☐ bladder problems	☐ incontinence	☐ pain with urination	☐ kidney stones		☐ NONE
INTEGUMENTARY	☐ rashes	☐ skin ulcers	☐ changes in skin			☐ NONE
NEUROLOGICAL	☐ headaches	☐ numbness/tingling	☐ seizures	☐ dizziness	☐ faintness	☐ NONE
MENTAL HEALTH	☐ depression	☐ sleep disorder	☐ nervousness	☐ fainting spells		☐ NONE
HEMATOLOGIC	☐ easy bleeding	☐ easy bruising	☐ bleeding problems			☐ NONE
ENDOCRINE	☐ thyroid problems	☐ low blood pressure	☐ thirst			☐ NONE
MUSCULOSKELETAL	☐ joint pain	☐ muscle pain	☐ cramps	☐ limitation in motor activity		☐ NONE

HISTORYPlease check all that apply (Family refers to parents, brothers, sisters, or children)

Condition	*You*	*Family*	*Condition*	*You*	*Family*	*Condition*	*You*	*Family*
Jaundice or Hepatitis	☐	☐	Diabetes	☐	☐	Sickle Cell	☐	☐
HIgh Blood Pressure	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐
Heart Attack	☐	☐	Gout	☐	☐	HIV/AIDS	☐	☐
Heart Disease	☐	☐	Alzheimer's	☐	☐	Stomach Ulcers	☐	☐
Emphysema	☐	☐	Stroke	☐	☐	Cancer Type ____________		
Asthma	☐	☐	Anemia	☐	☐			

Have you ever been diagnosed/treated for any other conditions/illness not listed above ______________________________

____

Women: Are you pregnant? **Yes** ☐ **No** ☐ Date of last menstrual period: ____________________

SOCIAL HISTORY:

Do you smoke? Yes ☐ No ☐ # of Years ________ Packs per day ____________________

Do you drink alcoholic beverages? Yes ☐ No ☐ Drinks per week____________________

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Number of Children ____________________

Occupation: ____ Currently Working: Yes ☐ No ☐

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

Patient Signature	Date

DO NOT SIGN BELOW UNLESS ASKED TO UPDATE YOUR FORM DURING A RETURN VISIT

I hereby certify that I have reviewed and updated the medical information on this form and it is currently accurate.

Patient Signature - Update # 1	Date	Physician Signature - Update # 1	Date
Patient Signature - Update # 2	Date	Physician Signature - Update # 2	Date
Patient Signature - Update # 3	Date	Physician Signature - Update # 3	Date

PHYSICAL EXAMINATION: **Patient Name:** ________________________________ **DOB:** __________

Vital Signs: B/P ________ P ________ R ________ T ________ Height ________ Weight ________

	Within Normal Limits Yes	No	Findings
HENT	☐	☐	____________________
Eyes	☐	☐	____________________
Neck	☐	☐	____________________
Heart	☐	☐	____________________
Lungs	☐	☐	____________________
Abdomen	☐	☐	____________________
Neurological	☐	☐	____________________
Musculoskeletal	☐	☐	____________________

Other Data ____

____

IMPRESSION/DIAGNOSIS: ____

PLAN:____

The patient has been advised of the plan and/or procedure, including the potential risks and benefits, and agrees to proceed.

Physician Signature ________________________________ Date ____________________