CENTER OF ORTHOPEDIC EXCELLENCE

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Date of Service:_____/_____/_____

Patient Name:_____ Date of Birth_____/_____/_____Age:_____ Sex: M F

Address:_____ Zip Code:_____ SSN#:_____

Telephone Numbers: Home:____--_____-_____ Work: _____-_____-_____ Cell:_____-_____-_____

Referring Physician:_____ Primary Care Physician:_____

What are we seeing you for today? (Chief Complaint)

_____

_____

When did the problem begin/Date of Injury? _____

How did the injury occur? _____

To be completed by office staff

Right/Left Handed Temp:_____

BP:_____/_____ Pulse:_____

Height:_____ Weight: _____

***IS THIS A WORK COMP INJURY CLAIM?** YES NO If yes, how?_____

Please describe the pain. (please circle) Constant Intermittent None Other:_____

Do you have? (please circle) Radiating pain Numbness Weakness If yes, where? _____

What type of pain are you experiencing? (please circle) Dull Achy Sharp Throbbing **Rate your pain _____ out of 10**

Is the problem (please circle) Getting worse Getting better Staying the same Is the pain present at rest? YES/NO

Do you have night pain? YES/NO Have you had X-Rays/MRI for this problem? YES/NO *If yes, where*?_____

What activities make the pain worse? _____

Have you had this problem before? YES NO If yes, describe._____

Have you seen another doctor for this problem? YES NO If yes, doctor's name:_____

Have you had treatment for this problem before? YES NO If yes, what type? _____

Past Medical History:

Do you have currently, or have you had in the past any of the following medical conditions/diseases?

☐ Liver	☐ Heart	☐ Lung	☐ Bleeding Tendencies	☐ Colitis
☐ Kidney	☐ Cancer	☐ High Blood Pressure	☐ Diabetes	☐ Stroke
☐ Asthma	☐ Hepatitis	☐ Low Blood Pressure	☐ Arthritis	☐ Seizure
☐ Tuberculosis	☐ Gout	☐ Sleep Apnea	☐ Blood Clots	☐ Thyroid

☐ Other, Explain:_____

Please list all previous surgeries, date performed, and performing physician:

_____

_____

_____

Family Medical History:

Do any of your immediate relatives have any of the following conditions/diseases?

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Strokes ☐ Heart Disease

☐ Arthritis/Gout ☐ Parkinson's Disease ☐ Epilepsy ☐ Tuberculosis

☐ Alcoholism ☐ Lung Disease ☐ Diabetes ☐ Kidney Disease

☐ Nervous Breakdown ☐ Bleeding Tendency ☐ Heart Attack ☐ Cancer(Type)_____

☐ Other:_____

If alive: If deceased:

Father: Age:_____ Health (circle one) Good Fair Poor Age:_____ Cause:_____

Mother: Age:_____ Health (circle one) Good Fair Poor Age:_____ Cause:_____

Social History:

Marital Status (circle one) Single Married Divorced Widowed Other:_____

Highest Level of Education:_____

Employment Status(circle one) Employed Retired Not Employed Disabled *If employed, where?*_____

Are you a smoker? ☐ No ☐ Yes *If yes, how much*? _____How much alcohol do you consume weekly?_____

*****Current Medications*****

*****Medication Allergies*****