

## Southeastern Orthopaedic Specialists

Date: \_\_\_\_\_ Chart # \_\_\_\_\_ Provider \_\_\_\_\_

Patient Name (Please Print) \_\_\_\_\_

BP _____ / _____	Pulse _____
Temp _____	H _____ / _____ W _____

Patient Signature \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  F  M Height \_\_\_\_ / \_\_\_\_ Weight \_\_\_\_\_

Who requested that you visit this office?  Doctor (Name) \_\_\_\_\_  Self-Referral  Attorney \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

\* What is the main reason for this visit?  Pain  Numbness  Weakness  Other \_\_\_\_\_ (Chief Complaint)

What body part is involved?							(Location)
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L	
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L	

How long has this problem been present? \_\_\_\_\_  Days  Weeks  Months

Check the box which best fits how your problem started. Then answer the one question below the box you checked. Use as much space to the right as needed.

<input type="checkbox"/> <b>NO INJURY (Onset was:</b> <input type="checkbox"/> Gradual or <input type="checkbox"/> Sudden)	<b>ANSWER:</b>
Why do you think it started?	_____
<b>INJURY - (NOT AUTO OR WORK)</b>	_____
Date _____, Where and How did it Happen?	_____
<b>INJURY AT WORK</b>	_____
Date _____, Where and How did it Happen?	_____
<b>WORK RELATED - (BUT NO INJURY)</b>	_____
Date _____, Where and How did it Happen?	_____
<b>AUTO ACCIDENT - Date / Details -</b>	_____
Driver / Passenger taken to ER?	_____

Please check the box below which best describes your problem:

**The pain is**  Constant  Comes and goes (Intermittent) (Duration)

**Severity of pain**  Mild  Moderate  Severe  Extremely Severe (Severity)

What is the **quality** of the pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning  
 Other: \_\_\_\_\_ (Quality)

Are these associated symptoms?  Swelling  Numbness  Weakness (Assoc Symp)

Since my problem started, it is:  Getting better  Getting worse  Unchanged (Context)

Does your pain wake you from sleep?  Yes  No (Timing)

What makes your symptoms **worse**?  Activity  Exercise  Work  Other \_\_\_\_\_ (Modify)

Which make you feel better?  Rest  Heat  Ice  Elevation  Other \_\_\_\_\_ (Modify)

What medications have you taken or been prescribed for this problem? \_\_\_\_\_ (Modify)

Check which treatments you have tried: Injection  Y  N Brace  Y  N Therapy  Y  N  
Cane/Crutch  Y  N (Modify)

**REVIEW OF SYSTEMS:** Do you have now, or have you ever had, any of the following health problems?

N2E3 1) **M/S** • Have you had a prior problem with this same Orthopaedic condition in the past?  Y  N (explain below)  
 (MS) \_\_\_\_\_

N3E4 2) **ARE YOU ALLERGIC TO ANY MEDICATIONS?**  Y  N If yes, please list \_\_\_\_\_  
 (2-9) \_\_\_\_\_

3) **ARE YOU A DIABETIC?**  Y  N TREATMENT:  Insulin  Oral Meds  Diet  None

(Please check all that apply, or mark None)

		None	Year	Explain Details/Comments
N4,5	4) <b>CON</b>	<input type="checkbox"/> weight loss <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Fever <input type="checkbox"/> Cancer	<input type="checkbox"/>	_____
E5	5) <b>EYE</b>	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Double Vision <input type="checkbox"/> Cataract	<input type="checkbox"/>	_____
(14)	6) <b>ENT</b>	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ringing in Ears	<input type="checkbox"/>	_____
	7) <b>CV</b>	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart attack <input type="checkbox"/> Blood clots	<input type="checkbox"/>	_____
	8) <b>RS</b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Pneumonia <input type="checkbox"/> Short of Breath <input type="checkbox"/> TB	<input type="checkbox"/>	_____
	9) <b>GI</b>	<input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Blood in Stool	<input type="checkbox"/>	_____
	10) <b>GU</b>	<input type="checkbox"/> Pain with urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney disease	<input type="checkbox"/>	_____
	11) <b>SK</b>	<input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Rash <input type="checkbox"/> Lumps	<input type="checkbox"/>	_____
	12) <b>NEU</b>	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Balance Problem <input type="checkbox"/> Headaches	<input type="checkbox"/>	_____
	13) <b>PSY</b>	<input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/>	_____
	14) <b>HEM</b>	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia	<input type="checkbox"/>	_____

**PAST MEDICAL HISTORY**

**LIST MEDICAL PROBLEMS:** \_\_\_\_\_

N3/E4 \* **WHAT MEDICATIONS DO YOU TAKE?**  None Please list with dosage: \_\_\_\_\_  
 (1) \_\_\_\_\_

N4,5 **ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BLOOD THINNERS?** Y N If yes, (type) \_\_\_\_\_  
 E5 \_\_\_\_\_

(1) **PAST HOSPITALIZATIONS (Not for surgery)**  None \_\_\_\_\_

**PAST SURGICAL HISTORY: What operations have you had? When?**  None \_\_\_\_\_

Have you ever had a reaction to anesthesia?  Y  N

**FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?**

E5 \* Any direct relative with the same Orthopaedic condition you are being seen for today?  Y  N \_\_\_\_\_

(1) Diabetes  Y  N \_\_\_\_\_ High Blood Pressure  Y  N \_\_\_\_\_ Heart disease  Y  N \_\_\_\_\_ Arthritis  Y  N \_\_\_\_\_

**SOCIAL HISTORY:**

E5 \* Do you use tobacco?  Y  N Packs per day \_\_\_\_\_ Alcohol use?  Y  N How often?  Daily  Other \_\_\_\_\_/week

(1) Marital History: M S D W \_\_\_\_\_ How many people live with you? \_\_\_\_\_

Occupation: \_\_\_\_\_  Student Employer: \_\_\_\_\_

Are you currently working?  Y  N If no, how long have you been off work? \_\_\_\_\_

**For office use only**

Reviewed for completeness by \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Reviewed by MD \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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