BONE & JOINT SPECIALISTS
ORTHOPEDIC & SPINE CENTER
Specializing in Arthroscopic Surgery, Hand Surgery, Foot & Ankle Surgery, Spine Surgery,
Joint Reconstruction, Sports Medicine, Podiatry, Workers Compensation

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Patient Name: _____ Date of Birth: _____/_____/_____

Reason for Visit: _____ R ❍ L ❍

Date pain began: _____/_____/_____ If injured, brief description: _____

If injured, where did it occur? ❍ work ❍ vehicle ❍ home ❍ other _____

If injured, date of injury: _____/_____/_____ Last day worked: _____/_____/_____

*List Prior Treatment: (physical therapy, anti-inflammatories, tests and/or injections) _____

_____

Name of family physician: _____ Who were you referred by: _____

Have you been diagnosed or treated for any of the following illnesses? (Please check all that apply)

❍ High Blood Pressure
❍ Diabetes
❍ Bladder/Kidney Disease
❍ Cancer (Type:_____)
❍ Heart Disease
❍ Depression
❍ Hepatitis
❍ Thyroid Disease
❍ Asthma
❍ Epilepsy/Seizures
❍ Hearing Problems
❍ Skin Conditions
❍ Arthritis
❍ Other _____
❒ MRSA
❒ TB
❒ HIV

Are you Claustrophobic?

❍ no ❍ mild ❍ moderate ❍ severe

SMOKING STATUS

❍ current every day smoker
❍ current some day smoker
❍ smoker, current status unknown
❍ never smoker
❍ former smoker
❍ unknown if ever smoked
❍ decline to answer

All Current Medications: _____

_____

Allergies: _____ ❍ No Known Allergies

Please list any surgeries and their dates: _____

_____

_____

Patient/Guarantor Signature: X _____ Date: _____/_____/_____

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Today's Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

REVIEW OF SYSTEMS Please check all that apply.

Constitutional	❍ Chills ❍ Fever ❍ Night Sweats ❍ Weight Loss ❍ Weight Gain
Eyes	❍ Near-sightedness ❍ Far-sightedness ❍ Astigmatism ❍ Double Vision ❍ Glaucoma
Ears	❍ Hearing Loss ❍ Tinnitus ❍ Vertigo
Nose, Mouth, Throat	❍ Rhinorrhea ❍ Congestion ❍ Sore Throat
CV	❍ Chest Pain ❍ Dyspnea on exertion ❍ SOB ❍ Orthopnea ❍ Edema Claudication
Respiratory	❍ Coughing ❍ Wheezing ❍ Difficulty Breathing ❍ Hemoptysis
GI	❍ Nausea ❍ Heartburn ❍ Bowel Irregularities ❍ Hemorrhoids
GU	❍ Frequency/Hesitancy ❍ Hematuria ❍ Incontinence ❍ Dysmenorrheai ❍ Amenorrhea
Musculoskeletal	❍ Arthralgia ❍ Effusion ❍ Neck Pain ❍ Back Pain
Integumentary	❍ Skin Lesions: ❍ stable ❍ changing ❍ Acne
Neurological	❍ Headaches ❍ LOC ❍ Seizures ❍ Paresthesia ❍ Gait Disturbance
Psychiatric	❍ Depression ❍ Mood-swings ❍ Hallucinations
Endocrine	❍ Excessive Thirst ❍ Frequent Urination ❍ Hyperactivity ❍ Difficulty Sleeping
Hematologic	❍ Easy Bruisability ❍ Anemia Epistaxis ❍ Excessive Blood Loss ❍ HIV Risk

FAMILY HISTORY

	Mother	Father	Brother	Sister	Son	Daughter
Anesthesia Complications						
Cardiovascular						
Cancer						
Hematologic						
Musculoskeletal						
Renal						
Endocrine						

Height _____ Weight _____ Flu Shot? ❍ YES ❍ NO Pneumonia Shot? ❍ YES ❍ NO

Pharmacy: Name _____ Address _____

SOCIAL HISTORY

Tobacco: _____ Pack/Day _____ Years (chewing tobacco, pipe, cigar)

Alcohol: Type _____ Amount _____ Frequency _____

Drug Use: Type _____ Amount _____ Frequency_____