Specializing in Arthroscopic Surgery, Hand Surgery, Foot & Ankle 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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Activities of Daily Living: (ADLs) are routine activities that people tend do every day without needing assistance. Please check all that apply from the list of activities that are being AFFECTED by your pain level.

❍ Walking - Moving around the house, store, etc.
❍ Climbing Stairs - Getting up and down stairs.
❍ Bathing - Getting into bath/shower; drying the body.
❍ Toileting - Sitting on and getting up from the toilet; wiping.
❍ Transferring bed/chair - Getting into and out of bed/chair.

Pain:

Rate the severity from 1-10 (10 being very severe) of your pain level: ______________________

What makes it worse? ______________________

What makes it better? ______________________

Describe the pain: ______________________

Do you use assistance to help with every day activities? ❍ Y or ❍ N (check one)

If yes, which device do you use? (check all that apply)

❍ Cane
❍ Walker
❍ Wheelchair
❍ Other: ______________________

How long have you been using this device(s)?

❍ 0-3 Months ❍ 3-6 Months ❍ 6-12 Months ❍ 12+ Months

Patient Signature: ______________________ Date: __________

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 ❍ Dysmenorrhea ❍ 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__________________________