BONE & JOINT SPECIALISTS
ORTHOPEDIC CENTER

Specializing in Arthroscopic Surgery, Hand Surgery, Foot & Ankle Surgery,
Joint Reconstruction, Sports Medicine, Podiatry, Workers Compensation

Scott Andrews, M.D.

9001 Broadway, Merrillville, IN 46410 • 219.795.3360 • Fax: 219.756.6500
2213 Main Street, Highland, IN 46322 • 219.795.3360
1354 S Lake Park Avenue, Hobart, IN 46342 • 219.795.3360

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_____