PATIENT INFORMATION

• Doctor you are seeing today: _____ • Appointment Date: _____

• PATIENT NAME _____

• PLEASE CHECK: ☐ Male ☐ Female • ARE YOU: ☐ Right ☐ Left Handed ☐ Ambidextrous

• BIRTH DATE _____ • AGE _____ • HEIGHT ____ ft _____ in • WEIGHT _____ lbs

• OCCUPATION: _____

☐FT / ☐PT / ☐ Self-Employed / ☐Unemployed / ☐Retired / ☐ Disabled / ☐FT Student / ☐PT Student

DOCTOR INFORMATION

Referring Doctor / Athletic Trainer / Physical Therapist / Friend

Family Medical Doctor

INJURY INFORMATION

• Date of injury or accident or onset of symptoms: _____

• Side of the body you are being seen for today (circle one): **LEFT** **RIGHT** **BILATERAL**

• **Please list body part(s):**_____

• Describe your injury/onset of your symptoms: _____

_____

_____

• ☐ **Work Injury?**

• ☐ **Auto Accident? Please sign below**

I hereby authorize my motor vehicle insurance carrier to release information to Professional Orthopaedic Associates regarding the PIP benefits that have been paid to date on my claim.

Signature: _____ Date: _____

PAIN ASSESSMENT

Please indicate the level of your pain for the injury listed above. Please circle the number below.

0 1 2 3 4 5 6 7 8 9 10

TREATMENT

• Have you been seen for a previous injury or symptoms for this body part? ☐Yes ☐No

If yes, by whom: _____

Seen in ER? When: _____ Where: _____

Treatments? ☐ Injection ☐ Physical Therapy ☐ NSAID / Pain Meds ☐ Brace
Tests/Scans Done? ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)
Where? _____ Did you bring them with you today? ☐ Yes ☐ No

PAST MEDICAL HISTORY ☐ None

Do you have any of the following medical problems? Please check all that apply:

☐ Anemia	☐ Heart Murmur	☐ Liver Disease/Hepatitis	☐ Pulmonary Emboli/Blood clots
☐ Asthma	☐ High Blood Pressure	☐ Lupus/SLE	☐ Rheumatoid Arthritis
☐ Diabetes	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Skin Rash/Psoriasis
☐ Emphysema/COPD	☐ Irregular Heartbeat	☐ Osteoarthritis	☐ Stroke
☐ Gout	☐ Irritable Bowel	☐ Osteoporosis	☐ Thyroid Disease
☐ Heart Attack /CAD	☐ Kidney Problems	☐ Phlebitis	☐ Ulcers

☐ Cancer- type: _____

- Have you fallen in the past year? ☐ Yes ☐ No
- If more than 2 times, please list how many: _____
- Were you injured? ☐ Yes ☐ No
- Do you feel unsteady when standing or walking? ☐ Yes ☐ No
- Do you worry about falling? ☐ Yes ☐ No

PAST SURGICAL HISTORY ☐ None

Please check and give the dates to all that apply.

	DATE		DATE		DATE		
☐ Appendix	_____	☐ Bowel/Colon	_____	☐ Breast Biopsy	_____		
☐ Gallbladder	_____	☐ Gynecologic	_____	☐ Heart Surgery	_____	☐ Pacemaker	_____
☐ Hernia Repair	_____	☐ Tonsils	_____	☐ Cosmetic Surgery	_____	(type & date)	

☐ ORTHOPAEDIC (please list all)_____

☐ Other surgery:_____

MEDICATIONS ☐ None

Do you take any of the following medications on a regular basis? Please check all that apply.

☐ Anti-Inflammatory ☐ Aspirin ☐ Birth Control Pills ☐ Coumadin/Xarelto/Eliquis

Please list any prescription medications you are currently taking: _____

_____

_____

ALLERGIES ☐None

Please list and/or check all that apply:

☐ Iodine ☐ Latex ☐NSAIDS ☐ Penicillin ☐ Sulfa/Sulfur

If not listed above, please provide:

Drugs:_____ Food:_____ Environmental:_____

Other:_____

PHARMACY INFORMATION

Please list your **complete** pharmacy information.

Name & Address:_____

FAMILY HISTORY

Please list any significant family medical history: _____

_____

SOCIAL HISTORY

Please check all that apply:

- Do you smoke tobacco/Vape? ☐ Every day? ☐ Some days? ☐ Never smoked? ☐ Former Smoker?

  How much per day/week? _____ Years smoked? _____ When quit? _____

- Do you drink alcohol? ☐No ☐Yes

  If **YES**, how many times, in the **past year,** have you had 5 (for men) or 4 (for women or if over 65) more drinks in a day?

  Please select one of the responses below.

  None **Once** **More Than Twice…..** in the past year (The federal government requires us to obtain this information)

- Have you ever been treated for chemical dependence? ☐No ☐Yes • Are you pregnant? ☐No ☐Yes

• Are you currently being treated for Osteoporosis or have you had any testing for Osteoporosis? ☐No ☐Yes

Please list any treatment and/or testing (i.e. Bone Density Test) you may have received and when: _____

REVIEW OF TODAY'S SYMPTOMS

Circle the SYMPTOM(S) that apply or if none apply circle: DENIES ANY

SYSTEM		SYMPTOMS				
Gastrointestinal	-	heartburn/ulcers	nausea/vomiting	bloody stools	hepatitis	liver disease
Endocrine	-	thyroid disease	heat/cold intolerable			
Constitutional	-	weight loss	loss of appetite			
Eyes	-	blurred vision	double vision	vision loss		
ENT	-	hearing loss	hoarseness	trouble swallowing		
Cardiovascular	-	chest pain	palpitations			
Respiratory	-	chronic cough	shortness of breath			
Genitourinary	-	painful urination	blood in urine	kidney problems		
Skin	-	frequent rashes	skin ulcers	lumps	psoriasis	
Neurologic	-	headaches	dizziness	seizures		
Psychiatric	-	depression	drug/alcohol addiction	sleep disorder		
Hematologic	-	easy bleeding	easy bruising	anemia		
Allergic	-	seasonal	other please list: _____			
Lymphatic	-	leg swelling				
Musculoskeletal	-	fracture	joint swelling	sprains	dislocation	
Vascular	-	claudication				