

Account # \_\_\_\_\_

**FIRST STATE ORTHOPAEDICS**

Date \_\_\_\_\_ Patient Name \_\_\_\_\_

**PATIENT'S CHIEF COMPLAINT**

Describe your medical problem or injury ( Right  Left) \_\_\_\_\_  
\_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_ Date of Injury \_\_\_\_\_

Doctors who have treated you for this problem \_\_\_\_\_

Have you been off work for this problem?  Yes  No Dates off work \_\_\_\_\_

Activities you participate in involving your injury: \_\_\_\_\_

Diagnostic Tests performed for current complaint:

- X-ray     MRI     CT/Scan     EMG     Bone Scan     Lab work

Have you ever had similar problems? If yes, please give details \_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF PRESENT INJURY**

Describe your pain:  Sharp  Dull  Throbbing  Achy  Other: \_\_\_\_\_

How severe is your pain?  Minor  Moderate  Severe

What is the duration of your pain?  Intermittent  Constant

When are you in pain?  All the time  Morning  Nights  With Exercise  Other: \_\_\_\_\_

Is your pain getting:  Worse  Better  Same

My pain is relieved when I:  Rest  Apply heat  Ice it  Elevate it  Other: \_\_\_\_\_

Associated signs/symptoms:  Bruising  Numbness  Tingling  Swelling  Limited range of motion  
 Other: \_\_\_\_\_

**For Office Use Only**

Dos _____	<input type="checkbox"/> Initial Visit	<input type="checkbox"/> Unable to Complete/Reason: _____	Dr: _____
Dos _____	No Change	<input type="checkbox"/> Update <input type="checkbox"/> Unable to Update/Reason: _____	Dr: _____
Dos _____	No Change	<input type="checkbox"/> Update <input type="checkbox"/> Unable to Update/Reason: _____	Dr: _____
Dos _____	No Change	<input type="checkbox"/> Update <input type="checkbox"/> Unable to Update/Reason: _____	Dr: _____
Dos _____	No Change	<input type="checkbox"/> Update <input type="checkbox"/> Unable to Update/Reason: _____	Dr: _____
Dos _____	No Change	<input type="checkbox"/> Update <input type="checkbox"/> Unable to Update/Reason: _____	Dr: _____
Dos _____	No Change	<input type="checkbox"/> Update <input type="checkbox"/> Unable to Update/Reason: _____	Dr: _____
Dos _____	No Change	<input type="checkbox"/> Update <input type="checkbox"/> Unable to Update/Reason: _____	Dr: _____

## PATIENT'S MEDICAL CONDITION

Right handed  Left handed

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs.

My weight in the last 6 months has:  Not changed  increased \_\_\_\_\_ lbs.  Decreased \_\_\_\_\_ lbs.

Please detail any special diet program you are on \_\_\_\_\_

Have you ever taken any anti-inflammatories/arthritis medications?  Yes  No (ex: Naprosyn/Ibuprofen) If yes, Please list \_\_\_\_\_

If you have had a problem with any of the following, please check

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> T.B.        |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Kidney Trouble      | <input type="checkbox"/> Skin Problems   | <input type="checkbox"/> V.D.        |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Sleep Apnea     | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Stomach Trouble | _____                                |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Recent Fevers       | <input type="checkbox"/> Substance Abuse | _____                                |

## PATIENT'S MEDICAL HISTORY

Smoker  Non Smoker

Consume Alcohol?  Yes  No

Please list any recent injuries, infections or illnesses \_\_\_\_\_

Please list any operations or hospitalizations \_\_\_\_\_

Have you ever had general anesthesia?  Yes  No

If yes, please describe complications, if any: \_\_\_\_\_

Have you ever been tested for HIV?  Yes  No If yes, result was:  Positive  Negative  Unknown

Have you ever been seen by another physician in this practice?  Yes  No If yes, Dr. \_\_\_\_\_

If you are a female between ages 10-18, what was the date of your first period? \_\_\_\_\_

Is your father living?  Yes  No If no, age deceased \_\_\_\_\_ cause of death \_\_\_\_\_

Is your mother living?  Yes  No If no, age deceased \_\_\_\_\_ cause of death \_\_\_\_\_

Are any of your brother/sisters deceased?  Yes  No If yes, date deceased \_\_\_\_\_ cause of death \_\_\_\_\_

Is there a family history of chronic/inherited diseases?  Yes  No

If yes, please describe \_\_\_\_\_

## SIGNATURE

Date: \_\_\_\_\_

Signature of Patient, Parent or Guardian: \_\_\_\_\_