The Centers for Advanced Orthopaedics

Center for Advanced Orthopaedics and Sports Medicine Division

Patients Name: _____ Today's Date: _____

Age: _____Height: _____ Weight: _____ Sex: M F Who referred you to this office: _____

Reason for today's visit: _____ Primary Care Physician: _____

On a scale of O through 10 (10 being the worst), how bad is your pain? Pharmacy: _____

0 1 2 3 4 5 6 7 8 9 10 Vaccines current: Yes No

Allergies: _____ Medications: _____

_____

Family History (specify relative):

High Blood Pressure _____ Cancer: _____

Stroke: _____ _____ Heart Problems: _____

Diabetes: _____ _____ Other: _____

Do you use tobacco: Yes Packs per day: _____ Previous smoker Never smoked

Are you currently employed: Full-time Part-time Student Disabled Unemployed Occupation: _____

Do you live: alone or with others Are you able to care for yourself: Yes No

Alcohol intake: None Occasional Moderate Heavy General Stress Level: Low Moderate High

Hand Dominance: Right Left Both Work Related: Yes No if yes, Date of injury: _____

Auto accident related: Yes No Other type of accident: Yes No If injured, is litigation ongoing: Yes No

Do you have an advanced directive or living will: Yes No Do you have: High Blood Pressure High Cholesterol HIV Risk Factors

Marital Status: Married Single Divorced Separated Widowed Domestic Partner

Number of Children: _____ Are they healthy: _____ Past Steroid use: Yes No

Surgical history: _____

_____

PAST MEDICAL HISTORY: Circle if it applies

AIDS/HIV	Anemia	Anxiety/Depression	Arthritis	Asthma	Bleed easily	Blood clots
Brusing	easily	Cancer	Chest Pain	Heart attack	Heart Problems	Hernia
High Cholesterol	Hypertension	Vision	Joint Pain/swelling	Kidney/bladder Disease	Liver Disease	Migraines/headaches
Osteoporosis	Pacemaker	Seizures/epilepsy	Stroke	Substance abuse	Thyroid problems	
Ulcers/heartburn	Skin conditions	Fatigue	Weight loss			

Patient Name: _____

History of Present Illness:

Hand Dominance: Left Right Ambidextrous Location: Left Right Bilateral

Quality: (*Circle all that apply*)

Aching Burning gnawing stabbing throbbing sharp dull deep

Occasional Frequent Constant Worsening Improving No change

Severity: No Pain Mild Moderate Severe

Duration: Date of onset: _____ # of days: _____ # of weeks: _____ # of months: _____

Timing: Cannot identify Gradual Sudden

When is pain worse: Day Night Continuous

Context: Cannot identify fall bending lifting twisting sports injury work injury
auto accident assault overuse laceration

What makes symptoms better: nothing sitting standing lying down position change
heat ice rest elevation over the counter meds
narcotics brace/sling

What makes symptoms worse:

cannot identify sitting standing lying down walking lifting

carrying twisting pushing/pulling gripping grasping squeezing

throwing exercise changing clothes getting out of bed going from sit to stand

Morning daytime nighttime cold weather

Are you having any: circle all that apply

Weakness numbness tingling swelling redness warmth

catching/locking popping/clicking grinding instability radiation down arm/leg

fever chills weight loss change in bowel or bladder habbits

Have you had previous surgery for this problem: Yes No

Have you had physical therapy for this problem: Yes No Did it help: No a little temporarily helped significantly

Work related: Yes No Date of injury: _____

Are you currently working: No regular duty modified duty

Procedures for this problem: Injection X-ray CT Scan MRI Other _____

Do you have a disc for the doctor to view today: Yes No