

# ORTHOPEDIC SURGICAL CONSULTANTS, P.A.

DATE \_\_\_\_\_ STAFF \_\_\_\_\_ MD \_\_\_\_\_ VITALS: BP \_\_\_\_\_ / \_\_\_\_\_ P \_\_\_\_\_ O2 \_\_\_\_\_ % RR \_\_\_\_\_ T \_\_\_\_\_ °

PATIENT HAS BEEN INFORMED OF VITAL SIGN RESULTS

Name \_\_\_\_\_  
Age \_\_\_\_\_

## ORTHOPEDIC HISTORY

WHO REFERRED YOU TO US?  
\_\_\_\_\_

WHAT PART OF THE BODY ARE YOU BEING SEEN FOR TODAY? \_\_\_\_\_

DATE OF INJURY (IF APPLICABLE), OR DURATION OF SYMPTOMS \_\_\_\_\_

HOW DID THIS PROBLEM START? (CHECK ONE & DESCRIBE INCIDENT)

- ONGOING PROBLEM / INCREASED SYMPTOMS \_\_\_\_\_
- WORK RELATED ACCIDENT \_\_\_\_\_
- CAR ACCIDENT \_\_\_\_\_
- OTHER INJURY \_\_\_\_\_

PLEASE CIRCLE ALL SYMPTOMS YOU ARE EXPERIENCING RELATED TO THIS PROBLEM:

- |                   |                   |                              |
|-------------------|-------------------|------------------------------|
| PAIN              | FEELING OF A MASS | DEFORMITY                    |
| CLICKING/ POPPING | SWELLING          | PROBLEMS WALKING OR STANDING |
| LOCKING           | TENDERNESS        | NUMBNESS / TINGLING          |
| STIFFNESS         | WEAKNESS          | CRAMPING                     |

HAVE YOU EVER HAD SURGERY OR TRAUMA TO THIS BODY PART BEFORE? NONE YES \_\_\_\_\_

OTHER PROVIDERS YOU HAVE SEEN FOR THIS PROBLEM NONE YES \_\_\_\_\_

TESTS YOU HAVE HAD DONE FOR THIS PROBLEM NONE YES \_\_\_\_\_

TREATMENT YOU HAVE ALREADY TRIED FOR THIS PROBLEM NONE YES \_\_\_\_\_

HEIGHT: \_\_\_\_\_  
WEIGHT: \_\_\_\_\_

## MEDICAL HISTORY

ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_

PRIMARY PHYSICIAN \_\_\_\_\_

DATE OF LAST VISIT \_\_\_\_\_

CURRENT MEDICATIONS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SURGERIES & HOSPITALIZATIONS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CIRCLE YES OR NO FOR ALL PAST AND PRESENT SYMPTOMS OR MEDICAL CONDITIONS:

Y	N	ARTHRITIS/ JOINT PAIN	_____
Y	N	BALANCE PROBLEMS	_____
Y	N	BLOOD/ BLEEDING DISORDERS	_____
Y	N	BOWEL / BLADDER PROBLEMS	_____
Y	N	CANCER	_____
Y	N	CHEMICAL DEPENDENCY	_____
Y	N	COMPLICATIONS FROM SURGERY	_____
		_____	_____
Y	N	DIABETES / ENDOCRINE DISORDER	_____
Y	N	DIGESTION PROBLEMS	_____
Y	N	EYES	_____
Y	N	EARS, NOSE, THROAT	_____
Y	N	EPILEPSY / SEIZURES	_____

Y	N	FAINING / BLACKOUT	_____
Y	N	FATIGUE, FEVERS, NIGHT SWEATS, CHILLS, OR UNEXPECTED WEIGHT LOSS	_____
Y	N	HEART CONDITIONS/ CHEST PAIN	_____
Y	N	HIGH BLOOD PRESSURE	_____
Y	N	IMMUNE DISORDERS/ AIDS	_____
Y	N	INFECTIONS	_____
Y	N	LUNGS, BREATHING	_____
Y	N	MENTAL HEALTH	_____
Y	N	RASHES /SKIN CONDITIONS	_____
Y	N	SMOKING HABIT: _____ PKS/DAY FOR _____ YRS	_____
DO YOU LIVE IN A SAFE ENVIRONMENT? _____			
ARE YOU PREGANT? NO POSSIBLY YES: DUE _____			

FAMILY HISTORY (PLEASE CIRCLE FOR MOTHER/ FATHER/ SIBLINGS): **NONE**

HIGH BLOOD PRESSURE    HEART PROBLEMS    DIABETES    STROKE    CANCER    MENTAL HEALTH    ANESTHESIA COMPLICATIONS