Room # _____

OrthoLouisiana
orthopedics • sports medicine

Patient Name: _____

Who requested that you visit this office? _____

Age: _____ **Height:** _____ **Weight:** _____

What body part is affected?

_Neck	Shoulder	Elbow	Pelvis	Knee	Ankle	Foot
Radiates to _r arm	_Right	_Right	_Right	_Right	_Right	_Right
_l arm	_Left	_Left	_Left	_Left	_Left	_Left

_Back	Arm	Wrist	Hip	Hand	Finger	Toe
Radiates to _r leg	_Right	_Right	_Right	_Right	_Right	_Right
_l leg	_Left	_Left	_Left	_Left	_Left	_Left

1) What is you MAIN reason for your visit today?

_____

2) How long has the problem been present? _____

3) Did an injury event please explain: _____

_____

Please check the box in each category that best describes your problem:

4) Severity of Pain? ____mild ____moderate ____severe ____extremely severe
5) Quality of Pain? ___sharp ___dull ___stabbing ___throbbing ___aching ___burning
6) What activities make your symptoms worse?
____standing ____ walking ____lifting ____exercise ____twisting ____sitting
____lying in bed ___ bending ___squatting ____kneeling ____stairs
7) What makes it better? ____rest ____ice ____elevation ___other _____
8) What medications have you tried for this problem? _____
9) Which treatment have you tried? ___injection ____brace ____therapy

List Medication:

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

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Past Medical History:

1) Do you have any medical problems? If so, please circle from the list below:

Diabetes	High Blood Pressure	Heart Problems	Hepatitis	Thyroid disease
Asthma	Rheumatoid Arthritis	Kidney Problems	Stroke	Tuberculosis
Ulcers	Emphysema	Blood Clots	Ulcers	Bronchitis

Other:_____

2) What previous orthopedic surgeries have you had?

_____

Review of the systems:

1) Have you ever had a prior problem with the same orthopedic condition you are here for today? _____yes _____no

2) _heartburn	_nausea	_vomiting	_blood in stool	_none
3) _excessive thirst	_heat or cold intolerance			_none
4) _weight loss	_fever			_none
5) _blurred vision	_double vision	_vision loss		_none
6) _ hearing loss	_hoarseness	_trouble swallowing		_none
7) _chest pain	_palpitations			_none
8) _chronic cough	_shortness of breath			_none
9) _painful urination	_blood in urine			_none

Family History:

Have any of your direct relatives had any of the following? Please circle all that apply.

___same orthopedic condition ___ rheumatoid arthritis ___diabetes
___high blood pressure ___ heart disease ___reaction to anesthesia

Social History:

Do you use tobacco products? ___no ___ yes _____ packs per day
Do you use alcohol? ____no ____yes
Marital History: ___Married ___Single ____ Divorced ____ Widowed
Occupation: _____ Employer: _____
Student: _____ Where: _____