Orthopaedic Surgical Associates

PLEASE COMPLETE THOROUGHLY, IF CONDITIONS DO NOT APPLY, PLEASE CIRCLE N/A
IF NOT FILLED OUT COMPLETELY, YOU WILL BE ASKED TO GO OVER FORM AGAIN

DATE: _____ **AGE:** _____
NAME: _____
Male / Female Right Handed / Left Handed
Height:_____ **Weight:**_____
Please describe your injury/illness:

Please circle all that you have been treated for and list any surgeries:

HEART: Chest Pain Palpitations Heart Failure Pacemaker **N/A**
Irregular Heart Rate Valve Replacement Hypertension
Hypercholesterol Phlebitis Cellulitis Lymphedema
Coronary Artery Disease Bypass Surgery Catherization
Angioplasty Stent Placement _____

LUNGS: Shortness of Breath Emphysema Pneumonia **N/A**
Asthma Pulmonary Embolism ___

GASTROINTESTINAL: Reflux Disease Hiatal Hernia **N/A**
Hemorrhoids Abdominal Aortic Aneurysm Gallstones
Gallbladder Removal Appendectomy Colon Resection
Hepatitis Bowel Incontinence _____

GENITOURINARY: Frequent Uninary Tract Infections **N/A**
Kidney Stones Enlarged Prostate Indwelling Catheter
Blader Incontinence Prostate Surgery Hysterectomy
_____

NEUROLOGICAL: Stroke Traumatic Brain Injury **N/A**
Closed Head Injury Intracranial Hemorrhage Herniated Disc
Carpal Tunnel Syndrome Sciatica Limb Numbness/Tingling
_____

MUSCULOSKELETAL: Fractures Osteoarthritis Neck Pain **N/A**
Rheumatoid Arthritis Osteoporosis Low Back Pain Scoliosis
Disc Disease _____

ENDOCRINE: Diabetes Hypothyroid **N/A**_____

MENTAL HEALTH: Depresion Anxiety Bipolar Disorder **N/A**
Panic Attacks Schizophrenia _____

CANCER: Location: **N/A** _____
Surgery: _____
Chemo: Yes / No Radiation: Yes / No

MEDICATIONS:
_____
_____
_____
_____
_____
_____

MEDICINE ALLERGIES: None
_____

SOCIAL HISTORY:
Patient Lives with: Spouse / Parents / Son / Daughter / Alone
Lives in a ____ Story House / Apartment / Townhouse / Mobile Home
____ Assisted Living Facility ____ Nursing Home
____ Steps to Enter House ____ Ramp ____ Elevator
____ Steps to the Second Floor
Bedroom and Bathroom on the First Floor: Yes / No
Occupation: _____
___ Currently Working ___ Not Working ___ Retired
Smoking/Vaping: Yes / No ____ Packs Per Day x ____ Years
___Vaping per day___Years Stopped Smoking ____ Years Ago
Alcohol: Yes / No Daily / Socially

IMMEDIATE FAMILY (Mom Dad, Siblings) MEDICAL HISTORY:

Family Member	Medical History Of
_____	_____
_____	_____

FUNCTIONAL HISTORY:
Do you need help with the following:

Yes	No	
_____	_____	Getting In/Out of bed
_____	_____	Feeding Yourself
_____	_____	Upper Body Dressing
_____	_____	Lower Body Dressing
_____	_____	Grooming Yourself
_____	_____	Bathing Yourself
_____	_____	Toileting
_____	_____	Getting In/Out of Chairs
_____	_____	Getting In/Out of Tub or Shower

Equipment Used For Walking: Cane Wheelchair Walker

REVIEW OF SYMPTOMS: (Please circle all that apply)
Cons: Fever Chills Weakness Insomnia Fatigue **N/A**
Eyes: Glasses Blurred Vision Double Vision **N/A**
ENT: Hearing Aid Tinnitus **N/A**
CVS: Chest Pain Palpitations DOE N/A
Resp: SOB Cough **N/A**
GI: Nausea Vomiting Diarrhea Constipation Incontinence **N/A**
GU: Burning Retention Incontinence **N/A**
Musc: Pain Weakness Decreased ROM N/A
Neuro: Numbness Tingling Burning "Pins & Needles" **N/A**
Psych: Depresion Anxiety **N/A**
Skin: Rash Ulceration Surgical Wound **N/A**
Lymph / Heme: Swollen Glands Increased Bruising or Bleeding **N/A**
Other: _____

PRIMARY CARE DR.: _____

OTHER DOCTORS YOU SEE: _____
_____