



Total Joint Replacement, Spine Surgery, General Orthopaedics, Sports Medicine, Arthroscopic Surgery

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

PARENT (IF MINOR): \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_

S.S.# \_\_\_\_\_ SEX:  M  F MARITAL STATUS  SING  MAR  DEV  WID

Was your injury the result of an accident?  Y  N

Are there Attorneys involved in the case?  Y  N

Will a lawsuit be filed in this case?  Y  N

CHIEF COMPLAINTS \_\_\_\_\_

LOCATION (where is the pain?) \_\_\_\_\_

RADIATION (which extremity does the pain radiate to?) \_\_\_\_\_

QUALITY (sharp, dull, stabbing) \_\_\_\_\_

DURATION (date of accident, how long have had pain?) \_\_\_\_\_

TIMING (when does the pain occur? How long does it last?) \_\_\_\_\_

CONTEXT (walking, sitting, sleeping: what makes it worse?) \_\_\_\_\_

MODIFYING FACTORS (what makes pain better?) \_\_\_\_\_

ASSOCIATED SIGNS AND SYMPTOMS (swelling, redness fever, etc.) \_\_\_\_\_

**PAST MEDICAL HISTORY (HEALTH)**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_

**MEDICATIONS: (Please List)**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_

**PAST SURGICAL HISTORY (OPERATIONS)**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_

**ALLERGIES: (Please List)**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_

**SOCIAL HISTORY:**

Alcoholic beverages (# per day) \_\_\_\_\_ Tobacco: cigarettes/cigars \_\_\_\_\_ packs a day for \_\_\_\_\_ Years.

Quit what year? \_\_\_\_\_

**WORK HISTORY:**

My job is \_\_\_\_\_

My job requirements are: \_\_\_\_\_

- Heavy – lifting over 60 pounds/frequent bending and stooping
- Medium – lifting 30-50 pounds
- Light – lifting 10-20 pounds
- Sedentary - sit most of the time – very little lifting
- My job is high stress level – it makes me tense
- How long disabled? \_\_\_\_\_