



Orthopaedics & Sports Medicine, P.A.

MEDICAL INFORMATION SHEET

Patient Name: _____ Age: _____ Date of Visit: _____

Female Male Weight _____ Height _____ Right Handed Left Handed

PRIMARY CARE PHYSICIAN'S NAME/PHONE: _____

Present Complaint: _____

When/how did this injury occur: _____

Was it related to a motor vehicle or work related injury _____

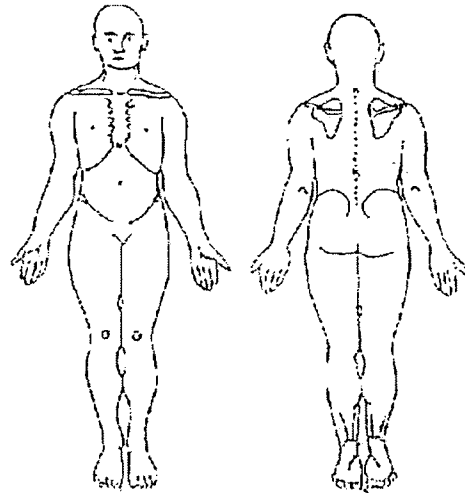
FOR PHYSICIAN USE ONLY – HISTORY OF PRESENT ILLNESS

(These are preliminary notes – refer to dictation for more details)

Empty box for physician notes

USING THE SYMBOLS BELOW, PLEASE DRAW IN THE LOCATION OF YOUR SYMPTOMS

- X = Pain
O = Numbness
/ = Aching
* = Pins and Needles



If you have NECK PAIN, what percentage is _____ % Neck and _____ % Arm (Total 100%)

If you have BACK PAIN, what percentage is _____ % Back and _____ % Leg (Total 100%)

Please indicate on the scale below your level of pain. (0 meaning no pain, 10 being the worst)

Least 0 1 2 3 4 5 6 7 8 9 10 Worst

Please put an X in the box if the positions make your pain Better or Worse

Table with 4 columns: Activity, Worse, Better, Comments. Rows include Bending, Bowel movement, Coughing, General Activity, Home Remedies, Lying down, Sitting, Standing, Walking.

PATIENT'S NAME _____

How long can you **STAND** with no or minimal pain _____ minutes

WALKING DISTANCE with no or minimal pain

0- 0-50 ft 50-200 ft 200-500 ft 500+ ft 1/2 mile +

Do you need **SUPPORT** to help you walk? Yes No If yes, what kind of support? _____

Do you wear a back or neck **BRACE**? Yes No If yes, what kind of brace? _____

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint.

Physician	Specialty	Dates	Treatment

Past Medical History – Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Other _____ | | |

PAST SURGICAL HISTORY

Type	Date	Outcome

Do you have any allergies?

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics/Mediations _____ | <input type="checkbox"/> Local or general Anesthesia |
| <input type="checkbox"/> Surgical Tape | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Iodine/Shellfish | <input type="checkbox"/> Other _____ |

CURRENT MEDICATIONS/DOSE

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

PATIENT'S NAME _____

SOCIAL HISTORY:

Occupation: _____ Marital Status _____ Education Level _____

Work Status: Full Duty Light Duty Off Duty per Physician Unemployed Retired

If you are NOT working full duty: How Long _____

Have you had a work capacity assessment Yes No

Are you disabled through Social Security Yes No

Tobacco Use: Yes No Cigarettes Cigars Chewing Tobacco (snuff)

Started Age/Year _____ Stopped _____ Quantity per day: _____

Alcohol Use: Do you consume alcoholic beverages Yes No

Beer Wine Distilled Spirits Quantity per day: _____

Have you ever been treated for drug or alcohol addiction? Yes No

SIGNIFICANT FAMILY HISTORY _____

REVIEW OF SYSTEMS:

CONSTITUTIONAL

Weight gain – last 6 months

Weight loss – last 6 months

Night Sweats

Chills

Fever

GASTROINTESTINAL

Nausea

Vomiting

Diarrhea

Indigestion

Abdominal pain

Bloody/dark stools

CARDIOVASCULAR

Chest pain

Palpitations

Shortness of breath w/exercise

Heart murmur

Feet edema

EYES/EAR/NOSE/THROAT

Recent changes in vision

Recent changes in hearing

Recent changes in smell

Recent changes in taste

Dizziness

GENITO-URINARY

Blood in urine

Urinary tract infection

Unable to control bladder

Unable to control bowel

Rushing to go

Need to go frequently

MUSCULOSKELETAL

Cramps

Attack of weakness

Joint pain/swelling

Morning stiffness

RESPIRATORY

Short of breath

Cough

Sputum

History of tuberculosis

Wheezing

CENTRAL NERVOUS

Poor Appetite

Problem sleeping

Numbness/tingling feet

Numbness/tingling hands

Crying spells

Convulsions

SKIN

Easy bleeding

Any rashes

Easy bruising

Who referred you to our practice?

Patient Primary Care Physician Another Physician Insurance Plan Online Directory

Patient's Signature _____

Physician's Signature _____