

Orthopedic Surgery First-Time Office Visit

YOUR BASIC INFORMATION:

Primary care doctor:	Name:			Age: _		Date of Birt	h:
Someone else Please list: Weight: REASON YOU ARE HERE TODAY: What is the problem or injury? How severe is the pain? (1-10 scale) Is this a work-related injury? Yes No Is this injury from a motor vehicle accident? Yes No ALLERGIES: NONE Latex Penicillin Aspirin Iodine Shellfish Other: MEDICATIONS YOU TAKE: OPERATIONS/SURGERY YOU HAVE HAD: Weight We	Primary care doctor:	 		Today's Date:			
REASON YOU ARE HERE TODAY: What is the problem or injury?	Did anyone refer you to	us? □ No	☐ Yes, my prim	nary care doctor		Height:	
What is the problem or injury? When did the problem start?		☐ Som	eone else [Pleas	se list:]	Weight:	
When did the problem start?	REASON YOU ARE HE	RE TODAY:				-	
Is this a work-related injury?	What is the problem or i	njury?					
Is this a work-related injury?	When did the problem s	How severe is th	e pain? (1-10 s	scale)			
ALLERGIES: NONE Latex Penicillin Aspirin lodine Shellfish Other: MEDICATIONS YOU TAKE: MEDICAL HISTORY: Check any health problems that you have or have had, write any that are not listed) Bleeding problems Kidney disease Arthritis Asthma Liver disease Gout Diabetes High blood pressure Hepatitis A B C Parkinson's HIV or AIDS Hart disease/heart attack Colitis Stroke/TIA High Cholesterol Atrial Fibrillation Diverticulitis Seizures Other: Pacemaker Ulcers/GERD Phlebitis/DVT (blood clot) Lung disease Thyroid problems Venereal disease COPD/emphysema Lupus Cancer [Type: HOW ARE YOU FEELING TODAY? (Check any symptoms that you have today, write any that are not listed) Weight gain Chest pain Joint pain Urinary infections Weight loss Shortness of breath Weakness Rashes Headaches Palpitations Paralysis Lumps Blackouts Cough Low back pain Dizziness Abdominal pain Painful urination Other: Dizziness Abdominal pain Painful urination Other: Diabetes Heart disease High blood pressure Arthritis Other: PERSONAL HISTORY: What kind of work do you do? Retired Disability Unemploye Marital status: Single Married Divorced Widowed Living situation: Alone w/Spouse w/Family w/Significant other Other Smoking: Most/every day Some days Former smoker Never smoked If yes, how much? For how many years?							
MEDICATIONS YOU TAKE: OPERATIONS/SURGERY YOU HAVE HAD: MEDICAL HISTORY: (Check any health problems that you have or have had, write any that are not listed) Bleeding problems Kidney disease Arthritis Diabetes	-	•					_
MEDICAL HISTORY: (Check any health problems that you have or have had, write any that are not listed) Bleeding problems				•			
Bleeding problems	OPERATIONS/SURGE	RY YOU HAVE I	HAD:				
Bleeding problems	MEDICAL HISTORY	(Chock any ho	alth problems th	at you have or ha	wo had write a	ny that are no	at listed)
Anemia				-		-	
Heart disease/heart attack							
Atrial Fibrillation	· ·		-	-			
□ Pacemaker □ Ulcers/GERD □ Phlebitis/DVT (blood clot) □ Lung disease □ Thyroid problems □ Venereal disease □ COPD/emphysema □ Lupus □ Cancer [Type:					· · · · · · · · · · · · · · · · · · ·		
□ Lung disease □ Thyroid problems □ Venereal disease □ COPD/emphysema □ Lupus □ Cancer [Type:							
HOW ARE YOU FEELING TODAY?: (Check any symptoms that you have today, write any that are not listed) Weight gain	☐ Lung disease ☐ Thyroid problems			☐ Vene	ereal disease	•	
Weight gain	☐ COPD/emphysema ☐ Lupus			☐ Can	cer [Type:]
Weight loss Shortness of breath Weakness Rashes Headaches Palpitations Paralysis Lumps Blackouts Cough Low back pain Other: Dizziness Abdominal pain Painful urination Other: MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: Bloody urine MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: Diabetes Heart disease High blood pressure Arthritis Other: PERSONAL HISTORY: What kind of work do you do? Retired Disability Unemployed Marital status: Single Married Divorced Widowed Living situation: Alone w/Spouse w/Family w/Significant other Other Smoking: Most/every day Some days Former smoker Never smoked If yes, how much? Some days For how many years? Do you drink any alcohol? Never Occasional Frequent	HOW ARE YOU FEELIN	IG TODAY?:	(Check any sy	mptoms that you	have today, wri	te any that ar	e not listed)
Headaches Palpitations Paralysis Lumps Blackouts Cough Low back pain Other: Double vision Bloody stool Bloody urine Other: MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: Diabetes					☐ Joint pain		•
Blackouts Cough Low back pain Dizziness Abdominal pain Painful urination Other: Double vision Bloody stool Bloody urine MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: Diabetes Heart disease High blood pressure Arthritis Other: PERSONAL HISTORY: What kind of work do you do? Retired Disability Unemployed Marrial status: Single Married Divorced Widowed Living situation: Alone W/Spouse W/Family W/Significant other Other Smoking: Most/every day Some days Former smoker Never smoked If yes, how much? For how many years? Do you drink any alcohol? Never Occasional Frequent	_				_		
□ Dizziness □ Abdominal pain □ Painful urination □ Other: □ Double vision □ Bloody stool □ Bloody urine MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: □ Diabetes □ Heart disease □ High blood pressure □ Arthritis □ Other: □ Diabetes □ Heart disease □ High blood pressure □ Arthritis □ Other: □ PERSONAL HISTORY: What kind of work do you do? □ Retired □ Disability □ Unemployed Marital status: □ Single □ Married □ Divorced □ Widowed Living situation: □ Alone □ w/Spouse □ w/Family □ w/Significant other □ Other Smoking: □ Most/every day □ Some days □ Former smoker □ Never smoked If yes, how much? □ For how many years? □ Do you drink any alcohol? □ Never □ Occasional □ Frequent					•		Lumps
MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: Diabetes							Other:
□ Diabetes □ Heart disease □ High blood pressure □ Arthritis □ Other: □ PERSONAL HISTORY: What kind of work do you do? What kind of work do you do? Married □ Divorced □ Widowed Living situation: □ Alone □ w/Spouse □ w/Family □ w/Significant other □ Other Smoking: □ Most/every day □ Some days □ Former smoker □ Never smoked If yes, how much? □ Never □ Occasional □ Frequent □ Divorced □ Widowed □ Widowed □ W/Significant other □ Other □ Never □ Never □ Never □ Personal □ Frequent □ Never □ Never □ Occasional □ Frequent □ Never □ Occasional □ Frequent	☐ Double vision	·			ody urine	-	
PERSONAL HISTORY: What kind of work do you do?	MEDICAL PROBLEMS	THAT RUN IN Y	OUR FAMILY:				
What kind of work do you do?	☐ Diabetes	☐ Heart diseas	e 🗆 High	n blood pressure	☐ Arthritis	☐ Other:	
Marital status: Single Married Divorced Widowed Living situation: Alone w/Spouse w/Family w/Significant other Other Smoking: Most/every day Some days Former smoker Never smoked If yes, how much? For how many years? Do you drink any alcohol? Never Occasional Frequent	PERSONAL HISTORY:						
Living situation: Alone w/Spouse w/Family w/Significant other Other Smoking: Most/every day Some days Former smoker Never smoked If yes, how much? For how many years? Do you drink any alcohol? Never Occasional Frequent	What kind of work do yo	u do?			☐ Retired	□ Disabilit	y 🗌 Unemployed
Smoking:	Marital status:	☐ Single	☐ Married	☐ Divorced	□ Widowed		
If yes, how much? For how many years? Do you drink any alcohol?	Living situation:	☐ Alone	☐ w/Spouse	\square w/Family	☐ w/Significa	nt other \square	Other
Do you drink any alcohol? ☐ Never ☐ Occasional ☐ Frequent	Smoking:	☐ Most/every o	ay □ Som	ne days	☐ Former sm	oker \square	Never smoked
		If yes, how muc	:h?		_	years?	
Do you use any other drugs?			□ Never	☐ Occasional	☐ Frequent		
	Do you use any other dr	rugs?	□ None				
REVIEWING PHYSICIAN PRINT NAME SIGNATURE/CREDENTIALS DATE/TIME	D=	nous Perse M		0.5			