

ORTHOPEDIC PATIENT PROFILE

Name: _____ Age: _____ Birth Date: ____/____/____

Dominant Hand: Right Left Ambidextrous Gender: Male Female

Occupation: _____ Employer: _____

School/Grade, if student: _____

Family Physician: _____

Referred by: Physician Hospital Family/Friend Advertisement Therapist Coach Other

What are we seeing you for today? _____

Were you injured? Y N If Yes, please list date of injury: _____

If No, how long has your pain been present overall? _____

And how long has it been this bad? _____

In regard to your **CURRENT PAIN**, circle all that apply to help describe it:

Quality: dull - sharp - throbbing - burning - other _____

Duration: constant - intermittent - occasional

Timing (pain is worse): in the morning - towards end of the day - at night - with activity - with stairs -
with weight bearing - getting out of a chair - with first few steps then improves

Alleviating factors: rest - ice - heat - compression - medicine - position change

Associated symptoms: swelling - locking - catching - giving way - weakness -
numbness - sweating - fevers - chills - night pain - falling

Severity: on a scale of 0 – 10, please rate your pain _____ (0 = no pain, 10 = worst pain of your life)

DRUG ALLERGIES AND REACTIONS: _____

Are you allergic to: Latex Adhesive tape Iodine (IV or Topical)

CURRENT MEDICATIONS/DOSAGES (include birth control and over the counter): _____

SOCIAL HISTORY

Do you live: alone - with spouse - with children - with parent(s) - in a nursing home

Marital status: single - married - divorced - widowed - separated - other

Do you smoke or chew tobacco: every day - some days - never - formerly Quit in _____

Alcohol: Y N If Yes, usually: beer - liquor - wine How often: rarely - occasionally - daily

Do you use illicit drugs? Y N If Yes, what and how often? _____

Have you ever been addicted to or overdosed on pain medicine? Y N

MEDICAL HISTORY		SURGICAL HISTORY		FAMILY HISTORY					
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Appendix	<input type="checkbox"/> Y <input type="checkbox"/> N	F	M	F = Father M = Mother	S = Sibling C = Child	S	C
Angina/chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Gall bladder	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis		<input type="checkbox"/>	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/> Y <input type="checkbox"/> N	Colon	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension		<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Stroke		<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Ovaries/Testes	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder		<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease		<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Prostate	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease		<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/> Y <input type="checkbox"/> N	Tubal ligation	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease		<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Hysterectomy	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease		<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	C-section	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis		<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder		<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart bypass	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness		<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart stent(s)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____		<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/Cirrhosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Vascular	<input type="checkbox"/> Y <input type="checkbox"/> N			_____			
Stomach ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N	Brain	<input type="checkbox"/> Y <input type="checkbox"/> N			_____			
Gastric reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsils/Adenoids	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin cancer	<input type="checkbox"/> Y <input type="checkbox"/> N			_____			
Kidney disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____				_____			
HIV / AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N					_____			
Rheumatoid Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	ORTHOPEDIC HISTORY (check if applicable)							
Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Total/partial knee replacement	<input type="checkbox"/> R <input type="checkbox"/> L						
Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Total/hemi hip replacement	<input type="checkbox"/> R <input type="checkbox"/> L						
Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Total/hemi shoulder replacement	<input type="checkbox"/> R <input type="checkbox"/> L						
MRSA	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Other total/partial joint replacement	_____						
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Knee ligament reconstruction (i.e. ACL)	<input type="checkbox"/> R <input type="checkbox"/> L						
Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Knee arthroscopy	<input type="checkbox"/> R <input type="checkbox"/> L						
Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Rotator cuff repair	<input type="checkbox"/> R <input type="checkbox"/> L						
Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Shoulder arthroscopy	<input type="checkbox"/> R <input type="checkbox"/> L						
Neuropathy	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Other joint arthroscopy	_____						
Cancer _____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____ Fracture repair	_____						
Other: _____		_____ Nerve release (i.e. carpal tunnel)	_____						
		_____ Back/Neck							

REVIEW OF SYSTEMS (please circle any that apply to you in the **past 30 days**)

Constitutional: fever - chills - fatigue - unexpected wt. gain - unexpected wt. loss

Eyes/Ears/Nose/Throat: blurry vision - ringing ears - nose bleeds - sore throat - hoarseness

Skin/Hematologic: rashes - ulcers/wounds - itching - bruising - anemia

CV/Resp: chest pain - palpitations - shortness of breath - cough - wheezing

GI: abdominal pain - indigestion - diarrhea - lack of appetite - nausea/vomiting

GU: painful urination - bloody urination - frequent urination - incontinence

Neuro/Psych: confusion - tremors - anxiety - hallucinations - seizures - dizziness

Height: _____ Weight: _____ BMI: _____ Temp: _____

Patient/Parent Signature _____ Date: _____

Physician Signature _____ Date: _____