ORTHOPEDIC SURGICAL CONSULTANTS, P.A.

DOS ________ STAFF ________ MD ________
VITALS: BP: ______/______ O2: _____% P: ______ RR: _____ T: ______

PLEASE PROVIDE A DESCRIPTION OF YOUR ORTHOPEDIC PROBLEM

NAME ______________________ **WHO REFERRED YOU TO US?** ______________________

AGE ______________________ **HEIGHT:** ______________ **WEIGHT:** ______________

WHAT PART(S) OF THE BODY ARE YOU BEING SEEN FOR TODAY?

1. ______________________

HOW DID THIS PROBLEM START?

□ NO KNOWN INJURY / PROBLEM IS ONGOING
DURATION OF SYMPTOMS: ___________________

□ SPECIFIC INJURY DATE: ___________________
- □ WORK RELATED ACCIDENT
- □ CAR ACCIDENT
- □ OTHER INJURY

2. ______________________

HOW DID THIS PROBLEM START?

□ NO KNOWN INJURY / PROBLEM IS ONGOING
DURATION OF SYMPTOMS: ___________________

□ SPECIFIC INJURY DATE: ___________________
- □ WORK RELATED ACCIDENT
- □ CAR ACCIDENT
- □ OTHER INJURY

BRIEFLY DESCRIBE YOUR INJURY OR SYMPTOMS IN YOUR OWN WORDS:

HAVE YOU EVER HAD SURGERY OR TRAUMA TO THIS BODY PART BEFORE? NONE YES ______________

OTHER PROVIDERS YOU HAVE SEEN FOR THIS PROBLEM NONE YES ______________

TESTS YOU HAVE HAD DONE FOR THIS PROBLEM NONE YES ______________

TREATMENT YOU HAVE ALREADY TRIED FOR THIS PROBLEM NONE YES ______________

GENERAL MEDICAL HISTORY

ALLERGIES: NONE KNOWN YES ______________________

PRIMARY PHYSICIAN: NONE YES ______________________

CURRENT MEDICATIONS: NONE
____
____
____

SURGERIES/ HOSPITALIZATIONS: NONE
____
____
____

PLEASE CIRCLE YES AND NO FOR ALL PAST AND PRESENT SYMPTOMS OR MEDICAL CONDITIONS:

Y N NORMAL GROWTH & DEVELOPMENT __________
Y N ARTHRITIS/ JOINT PAIN __________
Y N BALANCE PROBLEMS __________
Y N BLOOD/ BLEEDING DISORDERS __________
Y N BOWEL / BLADDER PROBLEMS __________
Y N CANCER __________
Y N CHEMICAL DEPENDENCY __________
Y N COMPLICATIONS FROM SURGERY __________
____
Y N DIABETES / ENDOCRINE DISORDER __________
Y N DIGESTION PROBLEMS __________
Y N EYES __________
Y N EARS, NOSE, THROAT __________
Y N EPILEPSY / SEIZURES __________

Y N FAINTING / BLACKOUT __________
Y N FATIGUE, FEVERS, NIGHT SWEATS, CHILLS, OR UNEXPECTED WEIGHT LOSS __________
Y N HEART CONDITIONS/ CHEST PAIN __________
Y N HIGH BLOOD PRESSURE __________
Y N IMMUNE DISORDERS/ AIDS __________
Y N INFECTIONS __________
Y N LUNGS, BREATHING __________
Y N MENTAL HEALTH __________
Y N RASHES /SKIN CONDITIONS __________

SMOKING HABIT: NONE QUIT SMOKING/ YR: __________
SMOKE: _________ PKS/ DAY FOR _________ YRS

DO YOU LIVE IN A SAFE ENVIRONMENT? __________

ARE YOU PREGANT? NO POSSIBLY YES: DUE DATE __________

FAMILY MEDICAL HISTORY

□ NO SIGNIFICANT FAMILY MEDICAL HISTORY

□ HIGH BLOOD PRESSURE
□ HEART PROBLEMS
□ MENTAL HEALTH
□ ANESTHESIA COMPLICATIONS

□ DIABETES
□ STROKE
□ CANCER