#

Advanced Orthopedic
& Sports Medicine Specialists

ALL INFORMATION IN THIS FORM IS CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD
FOR YOUR ANNUAL VISIT AND/OR INFORMATION UPDATE, PLEASE COMPLETE THE ENTIRE FORM
PLEASE DO NOT INDICATE "NO CHANGES" AS OUR FORM HAS RECENTLY BEEN REVISED

**NAME** _____ **TODAY'S DATE** ___ / ___ / ___

**AGE** _____ **BIRTHDATE** ___ / ___ / ___ **GENDER** ☐male ☐female ☐other
**OCCUPATION** _____ **PREFERRED LANGUAGE** _____
**RACE** _____ **ETHNICITY** _____ or ☐**PREFER NOT TO ANSWER**

**PRIMARY CARE PHYSICIAN** _____ **TEL** _____
**PRIMARY CARE PHYSICIAN CITY** _____ **ZIP** _____
**REFERRAL SOURCE** _____ **TEL** _____

**PHARMACY NAME** _____ **TEL** _____
**PHARMACY ADDRESS (cross street)** _____

**PLEASE DESCRIBE THE NATURE OF YOUR ISSUE AND HOW IT AFFECTS YOUR DAILY LIFE**
_____
_____
_____

**Is the issue** ☐New ☐Chronic ☐Exacerbation of an old injury/issue
**Approximate date of onset** ____/____/____
**Is the issue due to an injury?** ☐Y ☐N
☐Work Injury ☐Motor vehicle accident ☐Recreational ☐NA ☐Other _____

**FREQUENCY** ☐Intermittent ☐Occasional ☐Constant ☐Constant with worsening ☐Rare
**STATUS** ☐Unchanged ☐Better ☐Fluctuating ☐Stable ☐Improving ☐Worse ☐Resolved
**SEVERITY** ☐Mild ☐Mild/Mod ☐Moderate ☐Mod/severe ☐Severe ☐Incapacitating ☐Constant ☐Variable
**QUALITY** ☐Ache ☐Burn ☐Deep ☐Dull ☐Electrical ☐Sharp ☐Shooting ☐Stabbing ☐Superficial ☐Throbbing
**TIMING** ☐At night ☐At rest ☐Continuous ☐In the morning ☐Intermittent ☐With activity--☐Mild or ☐Strenuous

**AGGRAVATED BY**: ☐Nothing or ☐(Detail) _____
**RELIEVED BY**: ☐Nothing or ☐(Detail) _____

**Have you seen another physician for this issue?** ☐No ☐Yes–When and who _____

**What treatments/evaluations have you tried (mark if applicable)?**
☐Nothing ☐Exercise ☐Acupuncture ☐Bracing ☐Ice ☐Activity modification
☐Injections - describe _____ ☐Medications – describe _____
☐Physical Therapy or Chiropractic? – Who and how many times? _____
☐Other _____
☐Blood tests ____/____/_____ Type _____
☐Imaging (Details) _____

#

**NAME**_____
**DOB** _____ / _____ / _____

**HEIGHT** _____ **WEIGHT** _____ **HAND DOMINANCE** _____ **SHOE SIZE** _____

## MEDICATIONS

☐ **Check if list is attached of current medications**

**(Please include prescriptions, supplements, and alternative/herbal medications)**

| NAME | DOSE | FREQUENCY | REASON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES

**MEDICATION/DETAILS/REACTION**

**MEDICATION ALLERGIES** ☐Y ☐N _____
_____
_____

**METAL ALLERGIES** ☐Y ☐N _____
**LATEX ALLERGY** ☐Y ☐N _____
**OTHER ALLERGIES** ☐Y ☐N _____

## GENERAL REVIEW OF SYSTEMS (Mark any applicable current symptoms)

| | | | | |
|---|---|---|---|---|
| Constitutional | ☐None | ☐Fever/Chills | | ☐Other _____ |
| HEENT | ☐None | ☐Vision loss | | ☐Other _____ |
| Cardiovascular | ☐None | ☐Chest Pain | | ☐Other _____ |
| Respiratory | ☐None | ☐Shortness of breath | ☐Recent respiratory infection | ☐Other _____ |
| GI | ☐None | ☐Nausea/Vomiting | | ☐Other _____ |
| Musculoskeletal | ☐Negative except noted in HPI/chief complaint | | | ☐Other _____ |
| Skin | ☐None | ☐Rash | ☐Infection/History of MRSA | ☐Other _____ |
| Neurologic | ☐None | ☐Dizziness | ☐Seizures | ☐Other _____ |
| Endocrine | ☐None | ☐Hair loss | | ☐Other _____ |
| Hematologic | ☐None | ☐Bleeding | | ☐Other _____ |

## FEMALE PATIENTS ONLY

**DATE OF LAST MENSTRUATION** (approximate) _____
**PREGNANT** Yes ☐ No ☐ Unsure ☐ Prefer not to answer ☐
**BREASTFEEDING** Yes ☐ No ☐

#

**NAME**_____
**DOB** _____ / _____ / _____

## MEDICAL HISTORY (Please mark as applicable, if not applicable please leave blank)

| | ONGOING | RESOLVED | | ONGOING | RESOLVED | | ONGOING | RESOLVED |
|---|---|---|---|---|---|---|---|---|
| Alzheimer's disease | ☐ | ☐ | Elevated lipids | ☐ | ☐ | Renal/Kidney Disease | ☐ | ☐ |
| Anemia | ☐ | ☐ | Fibromyaligia | ☐ | ☐ | Scoliosis | ☐ | ☐ |
| Angina | ☐ | ☐ | Fracture | ☐ | ☐ | Seizures | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Gout | ☐ | ☐ | Sleep Apnea | ☐ | ☐ |
| Asthma | ☐ | ☐ | Headache | ☐ | ☐ | Spinal Stenosis | ☐ | ☐ |
| Cancer | ☐ | ☐ | Liver Disease | ☐ | ☐ | Spondyloarthropathy | ☐ | ☐ |
| Congestive Heart Failure | ☐ | ☐ | Hypertension | ☐ | ☐ | Stroke | ☐ | ☐ |
| COPD | ☐ | ☐ | Inflammatory bowel | ☐ | ☐ | Systemic Lupus | ☐ | ☐ |
| Coronary Disease | ☐ | ☐ | Lyme Disease | ☐ | ☐ | Thyroid Disesae | ☐ | ☐ |
| Crohn's Disese | ☐ | ☐ | Myocardial Infarct | ☐ | ☐ | Vascular Disease | ☐ | ☐ |
| DVT/Blood Clot | ☐ | ☐ | Obesity | ☐ | ☐ | | | |
| Depression | ☐ | ☐ | Osteoporosis | ☐ | ☐ | | | |
| Diabetes | ☐ | ☐ | Parkinson Disease | ☐ | ☐ | | | |
| Drug abuse | ☐ | ☐ | Peptic Ulcer | ☐ | ☐ | | | |
| Other | ☐ | ☐ | Psoriasis | ☐ | ☐ | | | |

**SPECIFIC HISTORY (CIRCLE)**: BLOOD CLOTS DIABETES JOINT INFECTION BONE TUMOR CANCER

## SURGICAL HISTORY (Please mark as applicable, date does not need to be exact)

| PROCEDURE | YEAR | PROCEDURE | YEAR | PROCEDURE | YEAR |
|---|---|---|---|---|---|
| ☐ACL Repair | _____ | ☐Carpal Tunnel Release | _____ | ☐Lasik | _____ |
| ☐Amputation | _____ | ☐Cataract | _____ | ☐Meniscus | _____ |
| ☐Angioplasty | _____ | ☐Cholecystectomy/gallbladder | _____ | ☐ORIF fracture | _____ |
| ☐Appendectomy | _____ | ☐Colectomy | _____ | ☐Rotator Cuff | _____ |
| ☐Arthroscopy | _____ | ☐Colostomy | _____ | ☐Small Bowel | _____ |
| ☐Back Surgery | _____ | ☐Gastric Bypass | _____ | ☐Thyroidectomy | _____ |
| ☐Blood Transfusion | _____ | ☐Hernia Repair | _____ | ☐Tonsillectomy | _____ |
| ☐CABG | _____ | ☐Hip Arthroplasty | _____ | ☐Other | _____ |
| ☐Cardiac Pacemaker | _____ | ☐Hip Replacement | _____ | _____ | _____ |
| ☐Cardiac Valve Replacement | _____ | ☐Knee Replacement | _____ | _____ | _____ |

HAVE YOU EXPERIENCED ANY ADVERSE EVENTS ASSOCIATED WITH SURGERY OR ANESTHESIA?
☐No ☐Yes IF SO, PERTINENT DETAILS: _____

## FAMILY HISTORY

| RELATION | AGE | ALIVE/DECEASED | HEALTH ISSUES |
|---|---|---|---|
| FATHER | | | |
| MOTHER | | | |
| SIBLING | | | |
| OTHER | | | |

## SOCIAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| TOBACCO | ☐Y | ☐N | ☐Daily | ☐Weekly | ☐# Years _____ |
| ALCOHOL | ☐Y | ☐N | ☐Daily | ☐Weekly | ☐# Years _____ |
| ILLICIT DRUGS | ☐Y | ☐N | ☐Daily | ☐Weekly | ☐# Years _____ |
| MARIJUANA | ☐Y | ☐N | ☐Daily | ☐Weekly | ☐# Years _____ |
| OTHER | _____ | | | | |

**HOW WOULD YOU RATE YOUR EXERCISE LEVEL?** ☐SEDENTARY ☐MILD ☐MODERATE ☐VIGOROUS
**PRE INJURY ACTIVITIES/HOBBIES/SPORTS** _____
**HOURS/WEEK YOU PARTICIPATE IN SPORTING ACTIVITIES WHEN YOU ARE HEALTHY** _____