NORTHSIDE | ORTHOPEDIC SPECIALISTS

A Northside Network Provider

Date: ____________________

Patient name: ______________________________ ☐ Male ☐ Female Date of birth: ______________

Height: ______ Weight: ______ Age: _____ Dominant hand: ☐ Right ☐ Left

Primary care physician: ______________________ Who referred you: ______________________

Current employer: ______________________ Occupation: ______________________

Name of School/Team: ______________________ ☐ N/A Sport(s): ______________________ ☐ N/A

Reason for today's visit: ***(Please complete one form per body part)*** ☐ Second Option

Affected side: ☐ Right ☐ Left

Body part: ☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand
☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot
☐ Neck / back ☐ Other: ______________________

Main complaint: ______________________

Briefly describe how it happened ______________________

Is your complaint a result of an injury? ☐ Yes ☐ No Date of injury: ______________

Work comp injury? ☐ Yes ☐ No If yes, are you currently working? ☐ Yes ☐ No

Average level of pain (0 - 10): _____ (Worse) At best (0 - 10): _____ (Worse) At worst (0 - 10): _____ (Worse)

Length of problem: ______________ Have you had this problem before? ☐ Yes ☐ No

Course of problem: ☐ Improving ☐ Worsening ☐ Staying the same ☐ Recurring

Timing: ☐ Intermittent ☐ Constant

Quality: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching

Associated symptoms: ☐ Swelling ☐ Bruising ☐ Catching / locking ☐ Instability / giving away
☐ Heat ☐ Numbness ☐ Weakness ☐ Loss of motion
☐ Night pain ☐ Radiating down leg ☐ Other: ______________

Aggravating symptoms: ☐ Bending over ☐ Reaching overhead ☐ Reaching behind back ☐ Lifting ☐ Throwing
☐ Sitting ☐ Grasping ☐ Exercise ☐ Weight bearing ☐ Previous surgery
☐ Stairs ☐ Standing ☐ Running ☐ Squatting ☐ Twisting ☐ None

Alleviating symptoms: ☐ Laying down ☐ Rest ☐ Ice ☐ Heat ☐ Stretching / Exercise
☐ PT/OT ☐ Use of walker or cane ☐ Elevation ☐ Movement
☐ Limited weight bearing ☐ Sitting ☐ None ☐ Other: __________

Prior evaluation or treatment for current problem: ☐ None

☐ X-rays ☐ ER/Office visit ☐ Cast / Splint ☐ Physical therapy / Occupational therapy
☐ MRI ☐ Injections ☐ Surgery ☐ Other: ______________

PATIENT INTAKE

Past Medical History		Family History (Please list family member) ☐ None
☐ High blood pressure	☐ Kidney disease ☐ Kidney stones	☐ High blood pressure
☐ Diabetes If yes, do you use insulin? ______	☐ HIV or AIDS ☐ Hepatitis Type _____	☐ Diabetes
☐ Thyroid problems	☐ Tuberculosis ☐ Tick bite ☐ MRSA history	☐ Heart disease
☐ Heart disease ☐ Heart attack ☐ Pacemaker	☐ Depression or psychiatric disorder	☐ Rheumatoid arthritis
☐ Cancer Type?____________________	☐ ADD/ADHD	☐ Cancer Type?____________________
☐ Blood clots (DVT/pulmonary embolism)	☐ Sickle cell anemia ☐ Anemia ☐ Bleeding problems	☐ Blood clots (DVT/pulmonary embolism)
☐ Stroke ☐ Peripheral neuropathy	☐ Rheumatoid arthritis	☐ Bleeding problems
☐ Rash/skin lesions	☐ Osteoporosis ☐ Osteoarthritis	☐ Stroke
☐ COPD ☐ Emphysema ☐ Asthma	☐ Seizures	☐ Osteoporosis
☐ Concussion	☐ Trouble with anesthesia	☐ Asthma
☐ Reflux/GERD or ☐ Stomach ulcer	☐ Sleep apnea ☐ Use of CPAP	☐ Trouble with anesthesia
☐ Gout	☐ Other:____________________________	☐ Other ________________________________

Review of Systems ☐ None					
Constitutional	☐ Fever	☐ Chills	☐ Weight loss		☐ Night sweats
Eyes	☐ Blurred vision	☐ Double vision	☐ Vision loss		
Ear/Nose/Throat	☐ Earache	☐ Hearing loss	☐ Throat pain		☐ Nose bleeds
Cardiovascular	☐ Chest pain	☐ Fast heart rate	☐ Palpitations		
Respiratory	☐ Cough	☐ Sleep apnea and ☐ Use of CPAP	☐ Difficulty breathing		☐ Wheezing
Gastrointestinal	☐ Nausea/vomiting	☐ Heartburn/ulcers	☐ Blood in stool		☐ Diarrhea
Genitourinary	☐ Painful urination	☐ Frequent urination	☐ Bladder/bowel changes		☐ Blood in urine
Musculoskeletal	☐ Joint stiffness	☐ Muscle aches	☐ Joint pain		☐ Muscle weakness
Skin	☐ Itching	☐ Skin lesion	☐ Skin rash		☐ Heat/cold tolerance
Neurologic	☐ Dizziness	☐ Vertigo	☐ Fainting		☐ Sensory/motor disturbances
Psychiatric	☐ Depression/Anxiety	☐ Drug/alcohol addiction	☐ Claustrophobic	☐ Sleep disorder	☐ Under care of Psychiatrist
Hematologic	☐ Easy bleeding	☐ Easy bruising	☐ Anemia		
Immunologic	☐ Hives	☐ Persistent infections			

List previous surgeries and dates: ☐ None

1. ____ Date:________________
2. ____ Date:________________

List current medications, dosages, and directions: ☐ None

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

List allergies and reactions: ☐ No known allergies

1. ______________________ 3. ______________________ ☐ **Latex** ☐ **Iodine**
2. ______________________ 4. ______________________ ☐ **Metal/Nickel**

Social History:

- Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
- Tobacco use: ☐ None ☐ Previous ☐ Current ________Amount/day
- Alcohol use: ☐ None ☐ Previous ☐ Current ________Amount/day
- Illegal drug use: ☐ None ☐ Previous ☐ Current If yes, what drug(s)? ________________________
- Physical Activity: How many days a week do you get moderate exercise? (e.g. Brisk walk) ______
  Duration: (e.g. Minutes) ______
- Are you currently **pregnant?**: ☐ Yes ☐ No **Nursing?**: ☐ Yes ☐ No
- Do you have any concerns about your safety?: ☐ Yes ☐ No

- **Flu shot** (this season): ☐ Yes (Date: _______________) ☐ No ☐ Declined
- **Pneumonia shot** (if over 65): ☐ Yes (Date: _______________) ☐ No

Signature:___________________________ Print name:___________________________ Date:__________________