SSMHealth
Orthopedics

MRN _____

Patient's Name: _____ Age: ___ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Referred by: _____

Pharmacy Name and Location: _____ Occupation: _____

Body part to examine today: _____ **Side affected**: ☐Left ☐Right **Dominant hand**: ☐Left ☐Right

Date of injury/Date symptoms first appeared: ___/___/___ Were you on the job when this injury occurred? _____
Have you filed a Worker's Compensation claim? _____

Describe your injury or symptoms: _____

_____

Liability case? ☐No ☐Yes Attorney's Name: _____

Were you seen in a hospital or ER? ☐No ☐Yes Name /location of facility: _____

Were xrays/MRI done? ☐No ☐Yes **Where?**_____ Brought in? ☐No ☐Yes ☐ CD ☐Film

List your current medications and dosages: _____

_____

_____

PLEASE MARK ANY DRUG ALLERGIES (check all that apply): ☐ No known drug allergies

☐Penicillin ☐Aspirin ☐Sulfa ☐Codeine ☐Xylocaine ☐Latex ☐Tape ☐Iodine ☐Other_____

Do you use tobacco products? ☐No ☐Yes Amount per day/week: _____ ☐Former Quit year: _____

Do you use alcohol? ☐No ☐Yes Amount per day/week: _____

Height _____ Weight _____ B/P _____

Previous surgery (list): _____

Previous fractures/broken bones (list): _____

PAST MEDICAL HISTORY	SELF	FAMILY	PAST MEDICAL HISTORY	SELF	FAMILY
HEART DISEASE			DVT / BLOOD CLOTS		
PACEMAKER			HEPATITIS C		
HIGH BLOOD PRESSURE			BLEEDING TENDENCIES		
STROKE			EPILEPSY/SEIZURES		
OBSTRUCTIVE SLEEP APNEA			**REVIEW OF SYSTEMS**	**SELF**	
LUNG PROBLEMS			CHEST PAIN		
DIABETES			SHORTNESS OF BREATH		
CANCER			EASY or PROLONGED BLEEDING or BRUISING		
WHAT PART OF THE BODY			NUMBNESS or TINGLING		
ULCERS			VISION CHANGES		
VASCULAR PROBLEMS			ABDOMINAL PAIN		
KIDNEY DISEASE			FEVER or CHILLS		
BLADDER INFECTION			RASH		
RHEUMATOID ARTHRITIS			BURNING or PAIN WITH URINATION		
ASTHMA			ANXIETY / DEPRESSION		
EMPHYSEMA / COPD					

Other Medical Conditions (list):_____

Signature of Patient or Parent/Guardian: _____ Date: _____

Physician's Signature: _____ Date: _____

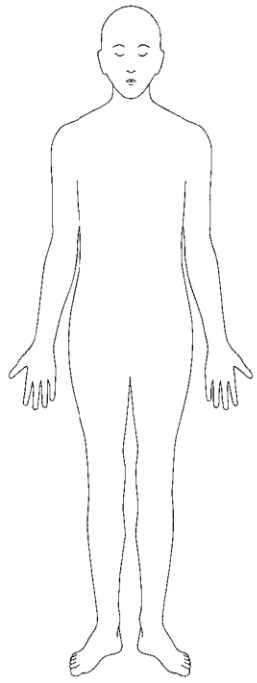
Through our exceptional health care services, we reveal the healing presence of God.

Name _____ Date _____

Where is your pain now?

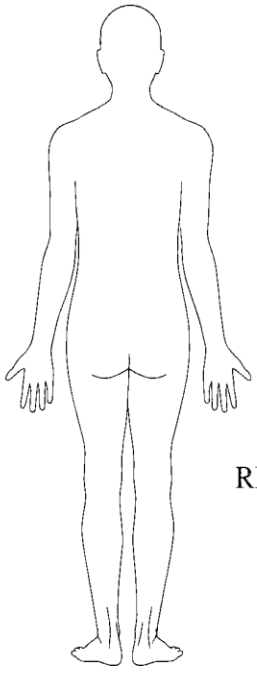
Mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Ache: ^^^^^^	**Numbness:** o o o o o	**Pins & Needles:** = = = = =	**Burning:** x x x x x	**Stabbing:** / / / / / /



RIGHT LEFT

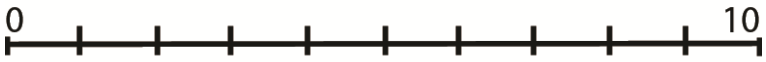
FRONT



LEFT RIGHT

BACK

How bad is your pain now? Mark an **X** on the line:



No pain at all Worst pain possible

Is there anything else you would like us to know pertaining to your visit today?

_____

_____

_____