OPELOUSAS ORTHOPAEDIC CLINIC

FOR OFFICE USE ONLY
DR:_____
CHART NO:_____

Patient Name:_____ Date:_____

Age:_____ Height:_____ Weight:_____ Sex:_____ Race:_____

Occupation_____ Employer_____ How long Employed_____

( ) RIGHT ( ) LEFT HANDED Education:_____

Where is the pain located?_____ ( ) Right ( ) Left

When did the pain start?_____ If injury, how and where did it happen?

_____

_____

Did you see a doctor? ( ) Yes ( ) No Doctor's Name if yes:_____

Were any test done (x-rays, MRI, blood work) for this problem? ( ) Yes ( ) No If Yes, when and where?

_____

Have you had any previous problems to this area? ( ) Yes ( ) No If so, when?_____

Do you have an attorney for this injury? ( ) Yes ( ) No If so, attorney's name:?_____

MEDICAL HISTORY OF PRESENT PROBLEM WHICH IS THE PRIMARY REASON FOR YOUR VISIT TODAY:
PLEASE CHOOSE ONLY 1 BODY PART

	Side: Left, Right or Bilateral						
Neck ☐	Shoulder ○○○	Wrist ○○○	Knee ○○○	○Fracture
Upper Back ☐	Upper Arm ○○○	Hand ○○○	Upper Leg ○○○	○Pain
Lower Back ☐	Lower Arm ○○○	Forearm ○○○	Lower Leg ○○○	○Swelling
Tail Bone ☐	Elbow ○○○	Hip ○○○	Ankle ○○○	
			Foot ○○○	

When did Symptoms First Appear? Date or Approximate Date ☐☐/☐☐/☐☐☐☐ Is condition getting worse? ○yes ○no

Your symptoms are aggravated by:

Have you ever had these symptoms before? ○yes ○no

☐bending ☐climbing stairs ☐descending stairs ☐lifting ☐movement
☐pushing ☐sitting ☐standing ☐walking other _____

Your symptoms are relieved by:

☐brace/splint ☐elevation ☐exercise ☐heat ☐ice ☐injection ☐massage ☐pain prescription meds
☐mobility ☐OTC meds ☐physical therapy ☐rest ☐stretching other _____

Severity of pain from 1 to 10 with 10 being the worst ☐☐ average ☐☐ at its worst

Type of pain:

☐aching ☐burning ☐dull ☐stabbing ☐sharp ☐throbbing
☐shooting ☐pins/needles ☐stiffness ☐cramps ☐numbness other _____

Have you had other treatment for this problem? ○yes ○no

If yes:
☐X-rays within last 6 months ☐☐/☐☐ Place _____ ☐MRI or CT Scan within last 6 months ☐☐/☐☐ Place _____

☐Prescribed meds ☐Physical Therapy ☐Surgery ☐Massage ☐Chiropractic ☐Injections ☐Bracing

Is your current problem injury related? ○yes ○no If yes, date of injury: ☐☐/☐☐/☐☐☐☐

Cause of injury: ○Work Accident ○Car Accident ○Home Accident
○Sports Activity ○School Activity ○Other _____

CONFIDENTIAL PATIENT PROFILE

Pharmacy Name _____ Pharmacy Phone Number ___-___-____

Pharmacy Address

_____ _____ ___ _____

Street or PO Box Number | City | State | Zip

CURRENT MEDICATIONS: Please list all current medications. IF UNSURE, CALL OR EMAIL AN ACCURATE LIST AS SOON AS POSSIBLE
Please include vitamins, over the counter medications and supplements.

	MEDICATION	DOSAGE	FREQUENCY		MEDICATION	DOSAGE	FREQUENCY
1				6			
2				7			
3				8			
4				9			
5				10			

PAST MEDICAL HISTORY - (Please check all that apply)

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Atrial Fibrillation
- ☐ Arthritis
- ☐ Asthma
- ☐ Enlarged Prostate
- ☐ Bleeding Disorders
- ☐ Cancer_____ (What Type) ____ (Year?)
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT/PE (Blood Clot)
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Hiatal Hernia
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Inflammatory Bowel Disease
- ☐ Irregular Heartbeat
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Motion Sickness
- ☐ MRSA (Staph Infection)
- ☐ Multiple Sclerosis
- ☐ Heart Attack ____ (Year?)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Other lung problems
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ Peripheral Vascular Disease
- ☐ Polio
- ☐ Renal Disease
- ☐ Scoliosis
- ☐ Seizure Disorder ____ (Year of last seizure?)
- ☐ Shortness of Breath
- ☐ Lupus
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Spondyloarthropathy
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Valvular Disease
- ☐ High Cholesterol
- ☐ Other Illnesses Not Mentioned

_____

_____

Have you ever had any of the following?

☐ MRI ☐ X-Ray ☐ EKG ☐ Bone Scan ☐ EMG/Nerve Conduction ☐ Ultrasound ☐ CT/CAT Scan

☐ Problems with anesthesia ☐ Injured by a metallic object or foreign body ☐ Stress Test

If yes to any above, please explain: _____

FAMILY HISTORY

☐ Arthritis ☐ Heart Attack ☐ Cancer _____ (Type) ☐ Diabetes ☐ DVT/PE (Blood Clot) Other _____

NAME_____ CHART #:_____

CONFIDENTIAL PATIENT PROFILE

PAST SURGERIES (Please note year and side where applicable)

	Year	Side: Left, Right or Bilateral
☐ ACL Surgery		(L) (R) (B)
☐ Angioplasty		
☐ Angio with stent		
☐ Appendectomy		
☐ Arthroscopy ankle		(L) (R) (B)
☐ Arthroscopy elbow		(L) (R) (B)
☐ Arthroscopy hip		(L) (R) (B)
☐ Arthroscopy knee		(L) (R) (B)
☐ Arthroscopy wrist		(L) (R) (B)
☐ Arthroscopy shoulder		(L) (R) (B)
☐ Coronary artery bypass graft		
☐ Cardiac valve replacment		
☐ Carpel tunnel release		(L) (R) (B)
☐ Cataract extraction		(L) (R) (B)
☐ Gallbladder surgery		
☐ Colectomy		
☐ Colostomy		
☐ Fracture Repair		(L) (R) (B)
What bone?		

	Year	Side: Left, Right or Bilateral
☐ Gastric bypass		
☐ Hernia repair		
☐ Hip replacement		(L) (R) (B)
☐ Knee replacement		(L) (R) (B)
☐ LASIK		(L) (R) (B)
☐ Meniscus surgery		(L) (R) (B)
☐ Muscle biopsy		(L) (R) (B)
☐ Pacemaker		
☐ Rotator cuff repair		(L) (R) (B)
☐ Small bowel resection		
☐ Thyroidectomy		
☐ Tonsillectomy		
☐ C-section		
☐ Tubal ligation		
☐ Hysterectomy		
☐ Prostate surgery		
☐ Shoulder replacement		
☐ Back/neck surgery		
☐ Dorsal Column Stim Pain Pump		

Other surgeries not listed above

	TYPE OF SURGERY	YEAR		TYPE OF SURGERY	YEAR
1			3		
2			4		

ALLERGY	REACTION	ALLERGY	REACTION

Do you have an allergy to: Latex - ◯ Yes ◯ No Contrast Dyes - ◯ Yes ◯ No Iodine / Shellfish ◯ Yes ◯ No

◯ Married ◯ Divorced ◯ Partner ◯ Single ◯ Widowed

Number of Children — Sons | Daughters

For Women: Is there a chance you may be Pregnant? ◯ Yes ◯ No

ALCOHOL ◯ Yes ◯ No

TOBACCO ◯ Yes ◯ No

Type	
Amount per day	
Last drink	
Type	
Amount per day	
Years used	
Year quit	

Recreational Drug Use List:

NAME_____ Height_____

CHART #: Weight_

CONFIDENTIAL PATIENT PROFILE

GENERAL HISTORY: (Review of Systems): Please check if any of these apply

CONSTITUTIONAL:
- ☐ Chills ☐ Fatigue
- ☐ Fever ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ **None of the above apply**

Other ☐

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ Cyanosis
- ☐ Heart Murmur
- ☐ Irregular heartbeat /palpitation
- ☐ Leg Swelling
- ☐ Syncope
- ☐ **None of the above apply**

Other ☐

INTEGUMENTARY:
- ☐ Contact allergy
- ☐ Itchy Skin
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesion
- ☐ **None of the above apply**

Other ☐

METABOLIC/ENDOCRINE:
- ☐ Cold intolerant
- ☐ Hair Loss
- ☐ Heat intolerant
- ☐ **None of the above apply**

Other ☐

HEENT:
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dysphagia (Difficulty Swallowing)
- ☐ Ear drainage
- ☐ Facial pain
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hoarsness
- ☐ Nasal congestion
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Vision loss
- ☐ **None of the above apply**

GASTROINTESTINAL:
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Black tarry stools
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ **None of the above apply**

Other ☐

NEUROLOGICAL:
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Poor coordination
- ☐ Memory loss
- ☐ Muscle weakness
- ☐ Paresthesia (Tingling)
- ☐ Seizures
- ☐ Tremors
- ☐ **None of the above apply**

Other ☐

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Other ☐

HEMATOLOGIC:
- ☐ Bleeding
- ☐ Bruising
- ☐ **None of the above apply**

Other ☐

RESPIRATORY:
- ☐ Chest pain (respiratory)
- ☐ Cough
- ☐ Dyspnea (Difficulty Breathing)
- ☐ Recent Infections
- ☐ Known TB exposure
- ☐ Wheezing
- ☐ **None of the above apply**

Other ☐

GENITOURINARY:
- ☐ Dysuria (Painful Urination)
- ☐ Frequent urination
- ☐ Hematuria (Blood in Urine)
- ☐ Urge incontinence
- ☐ Urinary incontinence
- ☐ **None of the above apply**

Other ☐

IMMUNOLOGICAL
- ☐ Asthma ☐ Bee Sting allergies
- ☐ Contact dermatitis
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies
- ☐ **None of the above apply**

Other ☐

Patient Signature ☐ Date ☐☐/☐☐/20☐☐

By my signature, I verify all the above information is correct to the best of my knowledge.

NAME:_____

CHART #:_____

PT NAME:_____

ACCT NO:_____

REVIEW OF SYSTEMS:

NO / YES Urinary

( ) ( ) Incontinence of urine
( ) ( ) Pain or burning on urination
( ) ( ) Frequent urination-day/night
( ) ( ) Kidney stones
( ) ( ) Urinary tract infection
( ) ( ) Extreme urge to urinate
( ) ( ) Difficulty starting and stopping stream

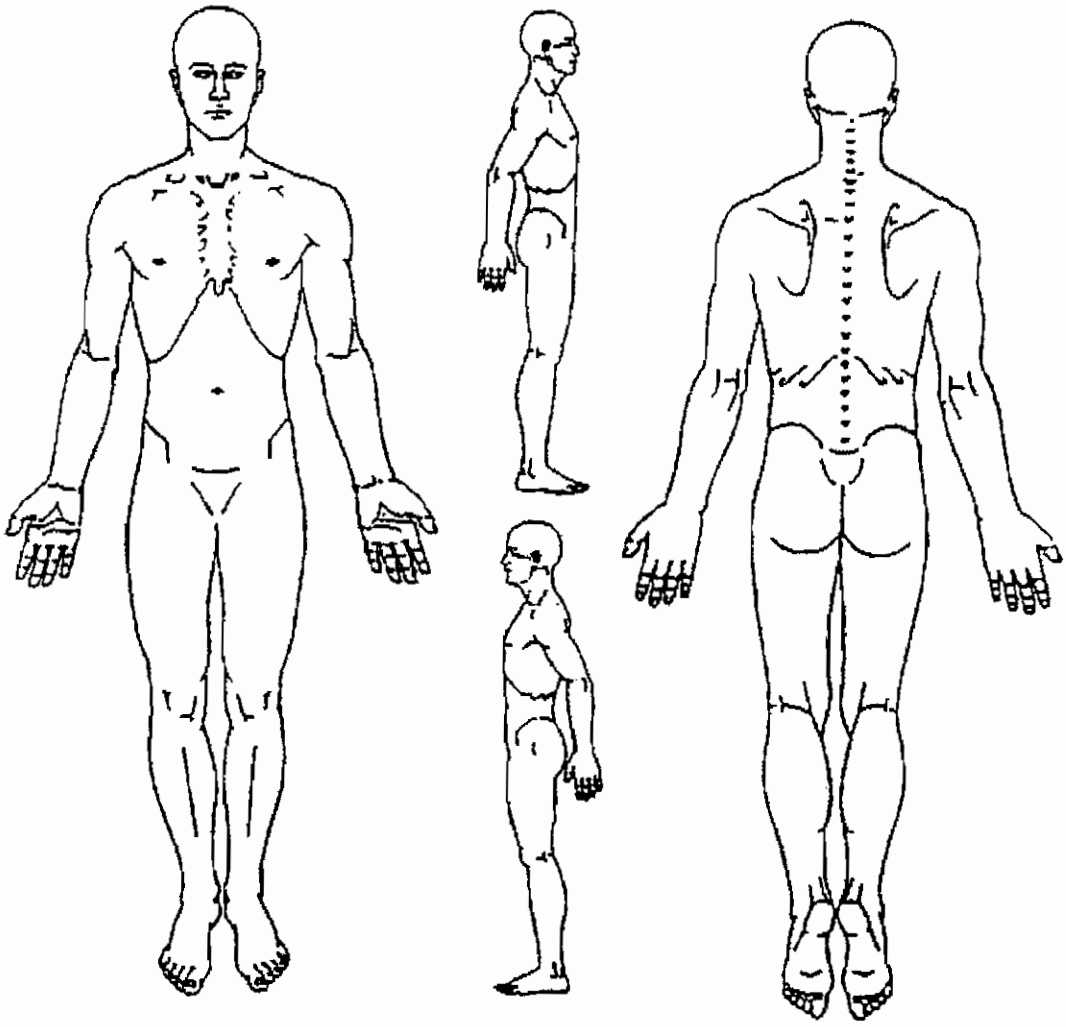
NO / YES Musculoskeletal

( ) ( ) Muscle pain
( ) ( ) Neck pain
( ) ( ) Shoulder or arm pain
( ) ( ) Back pain
( ) ( ) Pain down legs
( ) ( ) Pain in joints
( ) ( ) Swelling of any joints
( ) ( ) Redness of any joints
( ) ( ) Stiffness of any joints

WHERE IS YOUR PAIN NOW?

Mark the areas on the diagram below where you feel the described sensation using the appropriate symbol:

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
AAA	OOO	–	XXX	///



VISUAL ANALOG SCALE (VAS)

PLEASE MARK ON THE LINE WITH AN 'X' THE DEGREE OF PAIN YOU HAVE NOW

No Pain_____**Worst Pain**

ARE YOU NOW: BETTER:_____ **WORSE:**_____ **SAME:**_____ **SINCE THE PROCEDURE/INJURY**

Signature:_____ **Date:**_____