St. Clair Orthopedic Associates

Referring Physician: _____

Primary Care Physician: _____

May we send your physician(s) a report of this visit? ☐ Yes ☐ No

Your Current Problem:

Please describe the problem that brings you into the office today: _____

_____

Describe the symptoms and area affected (type of pain, swelling, numbness, etc.) _____

_____

When did this problem begin (date of injury)? _____

If you had an injury, how did it happen? _____

Is this a work related problem? ☐ Yes ☐ No If disabled, when did you last work _____

Is there an attorney involved with your case? ☐ Yes ☐ No If yes, who: _____

Social History:

What is your work status? ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ Homemaker

What is your occupation? _____

What level of activity is required in your workplace:

☐ Mild-desk job ☐ Moderate-standing, lifting ☐ Extensive-manual labor

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Do you have any children? ☐ Yes ☐ No If so, how many children? _____

Who lives at home with you? _____

Do you use tobacco? ☐ Yes ☐ No Did you previously use tobacco? ☐ Yes ☐ No

☐ Cigarettes____pack/day ☐ Pipe ☐ Cigar ☐ Chewing tobacco For how many years? _____

Do you use alcohol? ☐ Yes ☐ No If yes, # of drinks___Daily _____Weekly_____Monthly

Do you use any street drugs? ☐ Yes ☐ No If yes, describe: _____

Do you have any history of drug or alcohol abuse? ☐ Yes ☐ No If yes, describe: _____

Past Medical History:

Please check boxes of any past medical problems that you have had.

- ☐ None
- ☐ Lung Disease
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Ulcers
- ☐ Gastric Reflux/GERD
- ☐ Liver Disease
- ☐ Hepatitis A/ B/ C
- ☐ Alcoholism
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blood Clots (DVT)
- ☐ Bleeding Tendencies
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular Disease
- ☐ Kidney Disease
- ☐ Depression
- ☐ Cancer
- ☐ Heart Disease
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fractures
- ☐ Thyroid Disease
- ☐ Immune Disorder
- ☐ Seizure Disorders
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Mental Illness
- ☐ None
- ☐ Other _____

Past Surgical History:

Please list any operations that you have had in your lifetime.

Year	Type of Operation

Medications:

Please list all medications including over the counter medicines, herbals and prescription medications that you take.

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

Allergies:

Please list all medications and substances that you are allergic to.

Medication allergy	What reaction did you have?
☐ None	
☐ Penicillin	
☐ Sulfa	
☐ Iodine	
☐ Latex	
☐ Contrast dyes	
☐ Adhesive tape	
☐ Other (please specify)	

Family History:

Please check illnesses that have occurred in any of your blood relatives.

☐ Diabetes
☐ Lung Disease
☐ Tuberculosis (TB)
☐ Asthma
☐ Alcoholism
☐ Ulcers
☐ Hepatitis A/ B/ C/
☐ Gastrointestinal Disease
☐ Heart Disease
☐ High Blood Pressure
☐ Stroke
☐ Heart Attack
☐ Blood Clots (DVT)
☐ Bleeding Tendencies
☐ Coronary Artery Disease
☐ Peripheral Vascular Disease
☐ Cancer
☐ Arthritis
☐ Osteoporosis
☐ Seizure
☐ Depression
☐ Mental Illness
☐ Thyroid Disease
☐ Kidney Disease
☐ Other _____

Relation	Alive/Deceased	Age	Health Status/Cause of Death
Mother			
Father			
Sibling			
Sibling			
Sibling			

Review of Systems/Current Symptoms: **Height:**_____ **Weight:**_____

Are you currently having or have you recently had any of the following problems? (**Please circle**)

Constitutional

Recent weight loss	Yes	No
Recent fevers or chills	Yes	No
Night sweats	Yes	No
Difficulty sleeping	Yes	No

Ears, Nose , Throat

Hearing loss	Yes	No
Ringing in ears	Yes	No
Sinus problems	Yes	No
Sore throat	Yes	No
Active dental issues	Yes	No
Wear hearing aid or dentures	Yes	No

Cardiovascular

Irregular heart beat	Yes	No
Chest pain, angina	Yes	No
Bleeding problems	Yes	No
Blood clots	Yes	No
Swelling arms or legs	Yes	No

Respiratory

Shortness of breath	Yes	No
Cough	Yes	No
Breathing difficulties	Yes	No

Gastrointestinal

Heartburn	Yes	No
Nausea and /or vomiting	Yes	No
Changes in bowel habits	Yes	No
Blood in bowel movements	Yes	No

Musculoskeletal

Joint pain	Yes	No
Limb pain	Yes	No
Muscle weakness	Yes	No
Difficulty moving arm /leg	Yes	No
Swelling limb/joint	Yes	No

Eyes

Wear glasses or contacts	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Vision problems	Yes	No

Skin

Psoriasis or eczema	Yes	No
Open sores or cuts	Yes	No
Dermatitis - rash	Yes	No

Neurologic

Headaches	Yes	No
Dizziness	Yes	No
Falls	Yes	No
Memory problems	Yes	No
Balance problems	Yes	No
Numbness/tingling	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disorder	Yes	No

Cancer Yes No

What kind? _____

Genitourinary

Frequent bladder infections	Yes	No
Painful urination	Yes	No
Difficulty starting urination	Yes	No
Blood in urine	Yes	No

Mental Health

Depression	Yes	No
Anxiety	Yes	No

Other

List: _____

Patient signature:_____ Date:_____

Reviewed by:_____ Date:_____ Time:_____