Department of Orthopaedics and Sports Medicine
University of South Florida College of Medicine

http://health.usf.edu/medicine/orthopaedic

Date: _____ Referring MD: _____

Name: _____ Family MD: _____

Involved Body Part: R / L _____ Employer: _____

Date of Onset/Injury: _____ Work-Related: Yes No

How Injury Occurred: _____ Need return to work/school form? Yes No

Where Injury Occurred: _____ Last Full-Time Work Date: _____

Dominant Hand: Left-Handed Right-Handed

WHAT ARE YOU HERE TO BE SEEN FOR TODAY?

Where (*Example: bottom of foot, left hand, etc.*):_____

Type of pain (*Example: throbbing, dull, sharp, numb, etc.*): _____

How bad is your pain? **1 2 3 4 5 6 7 8 9 10**

How often (*Example: all day, few minutes, all night, etc.*): _____

When (*Example: upon arising, at the end of day, etc.*): _____

Activities (*Example: while typing, stooping, squatting, etc.*): _____

What makes it better/worse (*what improves or worsens symptoms*): _____

Other signs & symptoms (*Example: tingling, stiffness, etc.):* _____

Your Medical History (*Past or current illnesses*):

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Heart problems
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Cancer _____
- ☐ Blood clots
- ☐ Hepatitis / HIV
- ☐ Problems with anesthesia
- ☐ 'Loose' joints
- ☐ Other _____

Prior Surgeries (When?):

- ☐ Problems with anesthesia
- ☐ Tonsils / Adenoids
- ☐ Sinus / Ear surgery
- ☐ Thyroid
- ☐ Heart valve / Heart bypass
- ☐ Breast
- ☐ Hysterectomy / Tubal ligation
- ☐ C-section
- ☐ Appendix / gall bladder / prostate
- ☐ Hernia
- ☐ Fractures _____
- ☐ Bone / joint _____
- ☐ Other _____

Family Medical History (*list family illnesses*):

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Heart problems
- ☐ Osteoporosis
- ☐ Other _____
- ☐ 'Loose' joints
- ☐ Cancer _____
- ☐ Stroke
- ☐ Blood clots

REVIEW OF SYSTEMS:

Are you currently having any of the following symptoms?

☐ Recent weight gain / loss	☐ Heart palpitations	☐ Urinary problems
☐ Fevers / chills	☐ Chest pain	☐ Seizures
☐ Rashes	☐ Shortness of breath	☐ Anxiety
☐ Headaches	☐ Wheezing	☐ Depression
☐ Vision changes	☐ Nausea / vomiting	☐ Joint pain
☐ Coughs / colds	☐ Constipation / diarrhea	

Other health issues not listed above: _____

SOCIAL HISTORY:

Do you work outside the home? No Yes. If yes, occupation? _____

What physical activities do you do on a regular basis? _____ How Often? _____

Do you smoke? No Yes. If yes, how much and how long? _____

Do you consume alcohol? No Yes. If yes, how much and how long? _____

Any recreational drug use? No Yes. If yes, what and how often? _____

DRUG ALLERGIES (*list all*):

☐ Penicillin	☐ Iodine
☐ Sulfa	☐ Latex
☐ Insulin	☐ Codeine

Other: _____

MEDICATIONS CURRENTLY TAKING (*list all, including any herbals and supplements*):

Are you a resident of a skilled nursing facility? No Yes

If yes, name and address of the facility: _____

_____

Effective Dates: From: _____ To: _____

_____ _____

Patient/Guardian Signature Date Physician / Resident / PA Date