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
- ☐ Other ____
- ☐ Cancer ______________________
- ☐ Blood clots
- ☐ Hepatitis / HIV
- ☐ Problems with anesthesia
- ☐ 'Loose' joints

Prior Surgeries (When?):

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

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

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
- ☐ Sulfa
- ☐ Insulin
- ☐ Iodine
- ☐ Latex
- ☐ 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