

Department of Orthopaedics and Sports Medicine University of South Florida College of Medicine http://health.usf.edu/medicine/orthopaedic

Name:	Date:					. F	Referri	ng MD:					
Date of Onset/Injury:	Name:					. F	amily	MD: _					
Need return to work/school form? Yes No	Involve	ed Body Part: R / I	Ĺ			_ F	Employ	yer:					
Where Injury Occurred:	Date of	f Onset/Injury:				_ \	Work-I	Related:	Yes		No		
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?	How Ir	njury Occurred:				N	Need re	eturn to	work/so	chool f	orm?	Yes	No
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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.): High blood pressure Diabetes Heart problems Stroke Otteoprosis Otter Prior Surgeries (When?): Problems with anesthesia Tonsils / Adenoids Sinus / Ear surgery Heart valve / Heart bypass Heart valve / Heart bypass Fractures Bone / joint Cancer Hysterectomy / Tubal ligation C-section Appendix / gall bladder / prostate Hernia Heart valve / Heart bypass Fractures Bone / joint Cancer Loose' joints Cancer Loose' joints Cancer Loose' joints Cancer Heart problems Cancer Loose' joints Cancer Loose' joints Cancer Loose' joints Cancer Heart problems Cancer Heart problems Cancer Heart problems Cancer Heart problems Cancer Blood clots	Domin	ant Hand: Left-Han	ded Righ	t-Hande	ed								
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☐ Heart valve / Heart bypass ☐ Fractures ☐ Breast ☐ Bone / joint ☐ Other ☐ Chose' joints ☐ High blood pressure ☐ 'Loose' joints ☐ Diabetes ☐ Cancer ☐ Heart problems ☐ Stroke ☐ Osteoporosis ☐ Blood clots		Sinus / Ear surgery						Append	ix / gall	bladde	r / pros	state	
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REVIEW OF SYSTEMS:

If yes, name a	ident of a skilled and address of the es: From:	e facility:		o Yes			
If yes, name a	and address of th	e facility:					
-							
-							
Are you a res	ident of a skillec	l nursing facilit	y? N	o Yes			
MEDICAT:	IONS CURRI	ENTLY TAK	ING (li	ist all, including	any herbals and	d su	pplements):
Other:	lin 				Codeine		
□ Sulfa	a				Latex		
	LERGIES (list	all):		П	Iodine		
Any recreation	onal drug use? 1	No Yes. If ye	s, what	and how often?			
Do you consu	ime alcohol? N	o Yes. If ye	s, how i	much and how lon	g?		
Do you smok	e? No Y	es. If yes, how	much a	nd how long?			
							_ How Often?
•	outside the hom						
SOCIAL H			_				
		above:					
				_			
_	on changes ghs / colds			ausea / vomiting onstipation / diarrl	nea	Ш	Joint pain
_	daches			heezing			Depression
☐ Rash	nes			hortness of breath			Anxiety
	ent weight gain / ers / chills		_	eart palpitations hest pain			Urinary problems Seizures