Comprehensive Orthopedic History Form

Advocare Stafford Orthopedics 1168 Beacon Avenue Manahawkin, NJ 08050

Today's Date: ____/_____/_____ Date of Birth: _____/_____/_____

Name _____ Age _____ Height: _____ Weight: _____

Occupation _____ Right / Left-Handed Male / Female

Primary Care Physician: _____

Address: _____ Phone Number: _____

Who is the clinician requesting this consult?

Name_____

Address_____

Which pharmacy do you use for prescriptions?

Name_____

Town_____

Where is your pain or injury? RIGHT _____

LEFT _____

How long have you had your pain? _____

Is your pain/injury related to a: motor vehicle accident work accident accident other

Quality/Severity of pain? (*circle all that apply*) Mild/moderate/severe/none

Sharp/Dull/Achy/Burning/Pins/needles/numbness What reduces the pain: _____NOTHING

At night/continuously/intermittent/repetitive pattern What increases the pain: _____NOTHING

ALLERGIES: Please CIRCLE what applies to you, if NONE circle NONE

LATEX TAPE PENICILLIN SULFA LIDOCAINE NOVACAINE

SHELLFISH IV CONTRAST DYE CHICKEN FEATHERS EGGS

OTHER PLEASE LIST:

CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS if NONE circle NONE

NAME OF MEDICATION	DOSE	DIRECTIONS	REASON FOR TAKING

PAST MEDICAL HISTORY:

Please circle any of the following conditions you currently have or had in the past.

DIABETES	HYPERTENSION	MI/PACEMAKER
LIVER DISEASE	KIDNEY DISEASE	CANCER: _____
MRSA	BLOOD DISEASE: ____	OSTEOPOROSIS
OTHER:	NONE:	

PAST SURGICAL HISTORY

Please LIST any PAST surgeries Date of procedure, Name of procedure, Surgeon

SOCIAL HISTORY: Please CIRCLE

Alcohol Use: No Yes How Often? _____

Smoking: No
Yes Current Smoker How Much Per Day Vape Former Smoker

Drugs: No Yes Marijuana Opiates (Percocet, Oxycodone) IV Drugs

FAMILY HISTORY: Please CIRCLE any family history of below conditions

Member	Alive/Deceased	Age	Health Status/Cause of Death
Father:			
Mother:			

HEART DISEASE DIABETES HYPERTENSION MENTAL ILLNESS CANCER: _____

REVIEW OF SYSTEMS:

Please circle your CURRENT conditions. If NONE, please circle NONE

GENERAL: Fever Chills Generalized Weakness Weight Loss Other: _____ NONE

OPHTHALMOLOGIC: Blurred Vision Double Vision Glaucoma Other: _____ NONE

EARS, NOSE, THROAT: Hearing Loss Ringing in Ears Dizziness/Spinning Runny Nose Bloody Nose Difficulty Swallowing Sore Throat Other: _____ NONE

CARDIOVASCULAR: Chest Pain Irregular Heartbeat Palpitations High Blood Pressure Other: _____ NONE

RESPIRATORY: Asthma Shortness of Breath Cough Coughing Blood COPD Other: _____ NONE

GASTROINTESTINAL: Nausea Vomiting Diarrhea Constipation Black or Bloody Stools IBS Heartburn Reflux Other: _____ NONE

URINARY: Blood in Urine Frequent Urination Painful Urination Other: _____ NONE

MUSCULOSKELETAL: Arthritis Bursitis Fractures Gout Lyme's Disease Other: _____ NONE

NEUROLOGICAL: Fainting Headaches Seizures Stroke Other: _____ NONE

PSYCHOLOGIC: Anxiety Depression Other: _____ NONE

ENDOCRINE: Diabetes Type I Diabetes Type II, Controlled, Uncontrolled, How controlled? _____
Hyperthyroid Hypothyroid Goiter Other: _____ NONE

HEMATOLOGY: Bleeding Problems Cancer _____ Other: _____ NONE

INTEGUMENTARY: Eczema Ulcers Fungal Infections Warts Skin Cancer: _____ NONE

FOR THE PHYSICIANS USE ONLY:

Well-nourished Cachetic Increased body mass index

Dorsalis pedis pulses? Radial pulses? **Gait is:** normal antalgic ataxic **Mental Status:** Alert and oriented x 3 Confused

Skin: Rashes, scars, abrasions noted? **Mood:** anxious balanced **Sensation:** intact or diminished

SIGNED: _____ DATE: _____

CLINICIAN: _____