



Shore Orthopedic Associates

... a division of Shore Health Services, Inc.®

These questions are intended to help us provide better care to you. Thank You!

PATIENT SECTION

Name: _____ Date of Birth: _____ Today's Date: _____
Age: _____ F _____ M Dominant hand _____ Right _____ Left Height _____ Weight _____

Who requested that you visit this office? _____ Doctor (Name) _____ Self-Referral _____ Attorney _____

- (Chief Complaint) What is your main reason for this visit? _____ Pain _____ Weakness _____ Numbness _____ Other _____
- (Location) What body part is involved? (check below)

Neck <input type="checkbox"/>	and <input type="checkbox"/>	R arm <input type="checkbox"/>	Shoulder <input type="checkbox"/>	R <input type="checkbox"/>	Elbow <input type="checkbox"/>	R <input type="checkbox"/>	Hand <input type="checkbox"/>	R <input type="checkbox"/>	Pelvis <input type="checkbox"/>	R <input type="checkbox"/>	Knee <input type="checkbox"/>	R <input type="checkbox"/>	Foot <input type="checkbox"/>	R <input type="checkbox"/>
	radiates to <input type="checkbox"/>	L arm <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>
Back <input type="checkbox"/>	and <input type="checkbox"/>	R arm <input type="checkbox"/>	Arm <input type="checkbox"/>	R <input type="checkbox"/>	Wrist <input type="checkbox"/>	R <input type="checkbox"/>	Finger <input type="checkbox"/>	R <input type="checkbox"/>	Hip <input type="checkbox"/>	R <input type="checkbox"/>	Ankle <input type="checkbox"/>	R <input type="checkbox"/>	Toe <input type="checkbox"/>	R <input type="checkbox"/>
	radiates to <input type="checkbox"/>	L arm <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>		L <input type="checkbox"/>

- (Duration) How long has this problem been present? _____ Days _____ Weeks _____ Months _____ Years
- Check the ONE box below that best describes how your problem started. Then use the space to right to answer the ONE question below the box you checked. Use as much space as needed.

<input type="checkbox"/> NO INJURY (onset was: Gradual or Sudden)	ANSWER:
Why do you think it started?	_____
<input type="checkbox"/> AUTO ACCIDENT	_____
Date / How was car hit?	_____
<input type="checkbox"/> INJURY (from Accident or Sports)	_____
Date / Where and how did it happen?	_____
What sport? Did it happen at school?	_____
<input type="checkbox"/> INJURY AT WORK (Date)	_____
From a _____ lift _____ twist _____ bend _____ pull	_____
<input type="checkbox"/> WORK RELATED (But no Injury)	_____
Date / How did your job cause it?	_____

Please check the box in each category that best describes your problem:

- Severity of pain? _____ Mild _____ Moderate _____ Severe _____ Extremely Severe
- Quality of Pain? _____ Sharp _____ Dull _____ Stabbing _____ Throbbing _____ Aching _____ Burning
- Timing of Pain? _____ Constant _____ Comes & Goes Does pain wake you from sleep? _____ No _____ Yes
- Do you have? _____ Swelling _____ Bruising _____ Numbness _____ Tingling _____ Weakness _____ Loss of bladder control
- Since my problem started, it is: _____ Getting Better _____ Getting Worse _____ Unchanged
- What makes your symptoms worse? _____ Standing _____ Walking _____ Lifting _____ Exercise _____ Twisting _____ Lying in Bed
_____ Bending _____ Squatting _____ Kneeling _____ Stairs _____ Sitting _____ Coughing _____ Sneezing
- What makes it better? _____ Rest _____ Heat _____ Ice _____ Elevation _____ Other
- What medications have you taken for this problem? _____
- Which treatment have you tried? _____ Injection _____ Brace _____ Therapy _____ Cane/Crutch
- Were you seen in an Emergency Room for this problem? _____ No _____ Yes Which ER & Date? _____
- What tests have you had? _____ X-Rays _____ MRI _____ CT-Scan _____ Bone Scan _____ Nerve Test (EMG/NCS)
- Have you already had surgery for this problem? _____ No _____ Yes Surgeon's Name & Date _____

PAST MEDICAL HISTORY

- Do you take any prescription or non-prescription medications? _____ No _____ Yes (List Below)
- | | | | |
|------------|-------|------------|-------|
| Medication | Dose | Medication | Dose |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
- Are you ALLERGIC to any medications? _____ No _____ Yes, List _____
 - List other products that you are allergic to (i.e. eggs, latex, iodine): _____

please complete both sides of this form →



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4. Have you ever had SURGERY? No Yes (List Below)

Surgery	Date	Surgery	Date

5. Did you have any adverse reactions to anesthesia? No Yes, Describe _____

6. Do you have any MEDICAL PROBLEMS? No Yes (Circle Below)

Diabetes	High Blood Pressure	Heart Problems	Blood Clots	Asthma
Bronchitis	Kidney Problems	Thyroid Disease	Tuberculosis	Emphysema
Ulcers	Hepatitis	Seizures	Cancer	Stroke
Rheumatoid Arthritis	Other _____			

REVIEW OF SYSTEMS

1. Have you ever had a prior problem with the same Orthopedic condition you are here for today? No Yes

2. Do you have OTHER JOINTS with morning stiffness swelling pain? No Yes

(Please check any that apply to you or mark NONE.)

NONE

- 3. Heartburn Nausea Vomiting Blood in Stool Stomach Pain w/Medications _____
- 4. Excessive Thirst Heat or Cold Intolerance _____
- 5. Weight Loss Fever Loss of Appetite _____
- 6. Blurred Vision Double Vision Vision Loss _____
- 7. Hearing Loss Hoarseness Trouble Swallowing _____
- 8. Chest Pain Palpitations _____
- 9. Chronic Cough Shortness of Breath _____
- 10. Painful Urination Blood In Urine _____
- 11. Rash Skin Ulcers Lumps Psoriasis _____
- 12. Headaches Dizziness _____
- 13. Depression Drug/Alcohol Addiction Sleep Disorder Thoughts of harming yourself _____
- 14. Easy Bleeding Easy Bruising Anemia _____

FAMILY HISTORY

Has any direct relative had any of the following? (Circle those that apply)

Rheumatoid Arthritis	High Blood Pressure	Same Orthopedic Condition As You	Diabetes
		Heart Disease	Reaction to Anesthesia

SOCIAL HISTORY

Do you use tobacco? No Yes, Packs Per Day _____ Marital History: Single / Married / Widowed / Divorced

Do you use alcohol? No Yes, How Often? Daily Other _____

Occupation: _____ Employer: _____

Are you currently working? No Yes If No, how long have you been off work? _____

Patient's Signature: _____ Date: _____

NURSE SECTION

1. The date and time the patient was brought into the exam room: _____:_____ am/pm

2. The patient entered the exam room with: nothing crutches cane cast splint walker wheelchair stretcher
one person assist two person assist walker boot cast shoe Other: _____

3. The patient appears: AAOx3 disoriented agitated pleasant combative

Nurse's Signature: _____ Date: _____

PHYSICIAN SECTION

Amount of total time spent with the patient: _____ Time spent counseling: _____

Physician's Signature: _____ Date: _____

See office note dated the same for additional documentation