

ORTHOPEDIC PATIENT PROFILE

DATE: _____

NAME: _____ **AGE:** _____ **BIRTHDATE:** _____

OCCUPATION: _____ **FAMILY PHYSICIAN:** _____

For **MRI Purposes** do you have claustrophobia? Yes _____ No _____

MAIN COMPLAINT: (Reason you are seeing the Doctor)

IN REGARD TO YOUR CURRENT PAIN, Please circle those below that apply:

Quality of Pain: dull, sharp, throbbing, burning

Severity of Pain on a 0/10 scale, _____ 0 = no pain, 10 = worst pain of your life

Timing of Pain: am, pm, bedtime, relates to menstrual cycle

Duration: constant, intermittent, frequent

Modifying Factors: medicines help pain, ice/heat helps, rest helps

Associated Symptoms: decreases, weakness, fevers, chills, sweating, night pain, numbness

If an accident, do you have an attorney? Yes _____ No _____

Drug Allergies and Reaction to Medicines: _____

CURRENT MEDICINES: Name & Dose of each:

SOCIAL HISTORY: Mark those that apply

Married _____ **Divorced** _____ **Widowed** _____ **Single** _____ **Other** _____

Alcohol use: None _____ Daily _____ Weekly _____ Monthly _____ Doesn't Apply _____

Smoking: # of Packs per Day _____ How Many Years _____ Doesn't Apply _____

Caffeine/Coffee: Yes _____ No _____ How much a day _____

Check **ALL** those that apply to you, Leave blank if they don't apply

Medical History	Past Surgeries	Family History	Father	Mother
<input type="checkbox"/> Anemia	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Angina	<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Appendix	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Arthroscopy	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Atrial Fib	<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Colon Resection	<input type="checkbox"/> Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fractures	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Hernia	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Laparoscopy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Lasix Eye Surgery		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Mastectomy		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Migraines	<input type="checkbox"/> Nerve		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Prostate		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rotator Cuff		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Skin Cancer		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/> Spine		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tonsils /Adenoids		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> List Cancers	<input type="checkbox"/> Total Joints		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____	<input type="checkbox"/> Tubal Ligation		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> _____	<input type="checkbox"/> Vasectomy		<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYMPTOMS:

Mark those that currently apply to you

Otherwise if not marked these symptoms will be considered negative.

Arm/Leg Numbness ___ Frequent Bruising ___ Joint Pain/Swelling ___ Seizures ___
 Chronic Cough ___ Fever ___ Sinus Problems ___ Heat/Cold Intolerance ___ Rashes ___
 Blurred Vision ___ Bloody Stools ___ Chest Pain ___ Dizziness ___ Fever ___ Depression ___
 Shortness-of-Breath ___ Menstrual Irregularity ___ Urinary Burning/Frequency ___
 Weight Gain/Loss ___

HEIGHT: _____ **WEIGHT:** _____ **TEMP:** _____

Patient Signature: _____ **DATE:** _____

Physician Signature: _____ **DATE:** _____