OSI
ORTHOPEDICS & SPORTS MEDICINE

Date: _____/_____/_____

ORTHOPEDIC PATIENT PROFILE

Name: _____ Age: _____ Birth Date: _____/_____/_____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous Gender: ☐ Male ☐ Female

Occupation: _____ Employer: _____

School/Grade, if student: _____

Family Physician: _____

Referred by: ☐ Physician ☐ Hospital ☐ Family/Friend ☐ Advertisement ☐ Therapist ☐ Coach ☐ Other

What are we seeing you for today? _____

Were you injured? ☐ Y ☐ N If Yes, please list date of injury: _____

If No, how long has your pain been present overall? _____

And how long has it been this bad? _____

In regard to your **CURRENT PAIN**, circle all that apply to help describe it:

Quality: dull - sharp - throbbing - burning - other _____

Duration: constant - intermittent - occasional

Timing (pain is worse): in the morning - towards end of the day - at night - with activity - with stairs - with weight bearing - getting out of a chair - with first few steps then improves

Alleviating factors: rest - ice - heat - compression - medicine - position change

Associated symptoms: swelling - locking - catching - giving way - weakness - numbness - sweating - fevers - chills - night pain - falling

Severity: on a scale of 0-10, please rate your pain _____ (0 = no pain, 10 = worst pain of your life)

DRUG ALLERGIES AND REACTIONS: _____

_____

Are you allergic to: ☐ Latex ☐ Adhesive tape ☐ Iodine (IV or Topical)

CURRENT MEDICATIONS/DOSAGES (include birth control and over the counter): _____

_____

_____

_____

_____

SOCIAL HISTORY

Do you live: alone - with spouse - with children - with parent(s) - in a nursing home

Marital status: single - married - divorced - widowed - separated - other

Do you smoke or chew tobacco: every day - some days - never - formerly Quit in _____

Alcohol: ☐ Y ☐ N If Yes, usually: beer - liquor - wine How often: rarely - occasionally - daily

Do you use illicit drugs? ☐ Y ☐ N If Yes, what and how often? _____

Have you ever been addicted to or overdosed on pain medicine? ☐ Y ☐ N

Please Flip Over and Complete Backside

MEDICAL HISTORY

Anemia	☐ Y ☐ N
Angina/chest pain	☐ Y ☐ N
Anxiety	☐ Y ☐ N
Asthma	☐ Y ☐ N
Atrial Fibrillation	☐ Y ☐ N
Bleeding Disorders	☐ Y ☐ N
Blood Clots	☐ Y ☐ N
Cancer _____	☐ Y ☐ N
COPD	☐ Y ☐ N
Depression	☐ Y ☐ N
Diabetes	☐ Y ☐ N
Fibromyalgia	☐ Y ☐ N
Gastric Reflux	☐ Y ☐ N
Gout	☐ Y ☐ N
Heart Attack	☐ Y ☐ N
Heart Failure	☐ Y ☐ N
Hepatitis/Cirrhosis	☐ Y ☐ N
High Cholesterol	☐ Y ☐ N
HIV/AIDS	☐ Y ☐ N
Hypertension	☐ Y ☐ N
Kidney Disease	☐ Y ☐ N
MRSA	☐ Y ☐ N
Multiple Sclerosis	☐ Y ☐ N
Neuropathy	☐ Y ☐ N
Osteoporosis	☐ Y ☐ N
Rheumatoid Arthritis	☐ Y ☐ N
Seizures	☐ Y ☐ N
Sleep Apnea	☐ Y ☐ N
Stomach Ulcers	☐ Y ☐ N
Stroke/TIA	☐ Y ☐ N
Thyroid Disease	☐ Y ☐ N

Other: _____

_____

SURGICAL HISTORY

Appendix	☐ Y ☐ N
Brain	☐ Y ☐ N
Breast	☐ Y ☐ N
C-Section	☐ Y ☐ N
Colon	☐ Y ☐ N
Gallbladder	☐ Y ☐ N
Heart bypass	☐ Y ☐ N
Heart stent(s)	☐ Y ☐ N
Hernia	☐ Y ☐ N
Hysterectomy	☐ Y ☐ N
Kidney	☐ Y ☐ N
Lung	☐ Y ☐ N
Ovaries/Testes	☐ Y ☐ N
Prostate	☐ Y ☐ N
Skin cancer	☐ Y ☐ N
Tonsils/Adenoids	☐ Y ☐ N
Tubal ligation	☐ Y ☐ N
Vascular	☐ Y ☐ N

Other: _____

FAMILY HISTORY

F = Father S = Sibling
M = Mother C = Child

F	M		S	C
☐	☐	Arthritis	☐	☐
☐	☐	Diabetes	☐	☐
☐	☐	Hypertension	☐	☐
☐	☐	Stroke	☐	☐
☐	☐	Bleeding disorder	☐	☐
☐	☐	Heart disease	☐	☐
☐	☐	Lung disease	☐	☐
☐	☐	Autoimmune disease	☐	☐
☐	☐	Thyroid disease	☐	☐
☐	☐	Osteoporosis	☐	☐
☐	☐	Seizure disorder	☐	☐
☐	☐	Mental illness	☐	☐
☐	☐	Cancer: _____	☐	☐
		_____		
		_____		
☐	☐	Other: _____	☐	☐
		_____		
		_____		

ORTHOPEDIC HISTORY (check if applicable)

_____	Total/partial knee replacement ☐ R ☐ L
_____	Total/hemi hip replacement ☐ R ☐ L
_____	Total/hemi shoulder replacement ☐ R ☐ L
_____	Other total/partial joint replacement _____
_____	Knee ligament reconstruction (i.e. ACL) ☐ R ☐ L
_____	Knee arthroscopy ☐ R ☐ L
_____	Rotator cuff repair ☐ R ☐ L
_____	Shoulder arthroscopy ☐ R ☐ L
_____	Other joint arthroscopy _____
_____	Fracture repair _____
_____	Nerve release (i.e. carpal tunnel) _____
_____	Back/Neck _____

REVIEW OF SYSTEMS (please circle any that apply to you in the **<u>past 30 days</u>**)

Constitutional: fever - chills - fatigue - unexpected wt. gain - unexpected wt. loss ☐ **N/A**

Eyes/Ears/Nose/Throat: blurry vision - ringing ears - nose bleeds - sore throat - hoarseness ☐ **N/A**

Skin/Hematologic: rashes - ulcers/wounds - itching - bruising - anemia ☐ **N/A**

CV/Resp: chest pain - palpitations - shortness of breath - cough - wheezing ☐ **N/A**

GI: abdominal pain - indigestion - diarrhea - lack of appetite - nausea/vomiting ☐ **N/A**

GU: painful urination - bloody urination - frequent urination - incontinence ☐ **N/A**

Neuro/Psych: confusion - tremors - anxiety - hallucinations - seizures - dizziness ☐ **N/A**

Height: _____ Weight: _____ BMI: _____ Temp: _____

Patient/Parent Signature _____ Date: _____

Physician Signature _____ Date: _____

Updated 10/2017