Orthopedic Specialists of North Texas
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Name____ Date________________ Ht________ Wt_______ Age______
Date of Injury________________ Referred By___________________________ Family Physician ___________________________
Chief Complaint R or L _____________________________________ Pain Scale (1 to 10, 1 being least amount of pain) _______
Alleviating Factors _____________________________________Aggravating Factors_____________________________________
Details of Injury (How? Where? Any Treatment?)____
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Medical Problems (circle): high blood pressure, diabetes, COPD, ulcers/reflux, cancer ___________, stroke, hepatitis A/B/C/D, kidney disease, enlarged prostate, rheumatoid arthritis, blood clots, neck/back pain, fibromyalgia, lupus, asthma, coronary artery heart disease, atrial fibrillation, anemia, HIV, seizures, other:____

MEDICATIONS

FAMILY HISTORY	Alive/Dead	Age	Health Status
Father	A D		
Mother	A D		
Sister/Brother	A D		
Sister/Brother	A D		
Sister/Brother	A D		
Sister/Brother	A D		

DRUG ALLERGIES

HOSPITALIZATIONS OR SURGERY	Year	Surgeon/Hospital

Have you had any problems with general anesthesia? Y / N

If yes explain: ____________________
____
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REVIEW OF SYSTEMS: (Please check if you are currently or have had problems with these & describe)
Vision changes____________________ Ringing Ears______________________ Chest Pain_______________ Headaches_______________
Chronic cough_________________ Heartburn/ulcers_________________Frequent Urination_________________Joint pain______________
Dizziness_________________Rashes/skin ulcers___________________ Balance Problems___________ Frequent thirst_________________
Hair loss________________Easy bruise/bleed________________Depression_____________________Unexplained weight loss__________

SOCIAL HISTORY:
Marital Status: S M D W Do you live alone? Y / N Exercise Regularly (times/week)__________ Type_________________
Smoking: Y / N ___ Packs per day x ___yrs If quit smoking, when? ____ Alcohol use: Y / N Drinks per day___________
Drug use: Y / N What? __________________________________ Years_______ Drug Rehab: Y / N
Do you use assistive device for ambulation? Y/N Cane/walker/scooter/wheelchair
Occupation_____________________

Signature:____

Physician Notes:

Physician Signature:____