Casscells
Orthopaedics & Sports Medicine

Patient Name: _____

DOB & Age: _____ Marital Status: _____

REASON FOR VISIT

Complaint & Body Part: _____ Right ◯ Left ◯ Bilateral ◯

HISTORY OF PRESENT INJURY

Please circle all that apply

When did the pain start? _____ **Have you been off work for this problem?** Yes ◯ No ◯ **Dates off work:** _____

Doctors who have treated you for this problem: _____ When: _____

Diagnostic tests and treatment performed *(please list when/where/what):*

X-Ray _____

MRI _____ Injection _____ Surgery _____

NSAIDS (anti-inflammatories)_ _____ EMG _____

CT/Scan _____ Bone Scan _____ Lab Work _____

PT _____ Other _____

Have you ever had similar problems? Yes ◯ No ◯ **If yes, please give details:** _____

PLEASE CIRCLE BELOW EACH AREA TO ASSIST IN DESCRIBING YOUR COMPLAINT:

Severity: ◯ Mild ◯ Moderate ◯ Severe

Status: ◯ Improving ◯ Resolved ◯ Stable ◯ Worse

Frequency: ◯ Occasional ◯ Constant ◯ Rare

Quality: ◯ Aching ◯ Burning ◯ Dull ◯ Radiating ◯ Sharp ◯ Throbbing

Aggravated By:

- ☐ Bending
- ☐ Climbing/Decending Stairs
- ☐ Lifting
- ☐ Pushing
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Other: _____

Relieved By:

- ☐ Brace/Splint
- ☐ Elevation
- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Pain/Rx Meds: _____
- ☐ OTC Meds: _____
- ☐ Rest
- ☐ Other: _____

Associated Symptoms/Pertinent Negatives:

- ☐ Bruising
- ☐ Crepitus (cracking sounds)
- ☐ Decreased Mobility
- ☐ Instability
- ☐ Limping
- ☐ Locking
- ☐ Night pain
- ☐ Numbness/Tingling
- ☐ Popping
- ☐ Swelling
- ☐ Weakness
- ☐ Other: _____

REVIEW OF SYSTEMS

Do you have any of the following symptoms? (Please circle all that apply)

Constitutional:

- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Gastrointestinal:

- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Cardiovascular:

- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/ Palpatations

Immunological:

- ☐ Environmental Allergies
- ☐ Food Allergies

Genitourinary:

- ☐ Dysuria
- ☐ Hematuria

Integumetary/Skin:

- ☐ Rash

Hematologic/Blood:

- ☐ Bleeding

Neurological:

- ☐ Difficulty Walking
- ☐ Dizziness

Respitory:

- ☐ Cough
- ☐ Dyspnea

HEENT:

- ☐ Headache
- ☐ Vision Loss

Metabolic/Endocrine:

- ☐ Cold Intolerant
- ☐ Heat Intolerant

Other: _____

Other: _____

Other: _____

☐ **None**

PATIENT'S SOCIAL HISTORY

Height: ____ ft ___ in Weight: ____lbs. **Hand Dominance: (circle one)** Left ◯ Right ◯ Ambidextrous ◯

Tobacco Use: Yes ◯ No ◯ Former/Year Quit _____ Consume Alcohol: Yes ◯ No ◯ Former/Year Quit _____

Type of Exercise: _____

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PATIENT'S FAMILY HISTORY

Is your Father Living? Yes ◯ No ◯ If no, age deceased _____ Cause of death: _____

Is your Mother Living? Yes ◯ No ◯ If no, age deceased _____ Cause of death: _____

Are any of your brothers/sisters deceased? Yes ◯ No ◯ If yes, age deceased _____ Cause of death: _____

Family history of chronic/inherited diseases: _____

PATIENT'S SURGICAL HISTORY

(Please circle all that apply & list year and side)

- ☐ ACL Surgery
- ☐ Appendectomy
- ☐ Athroscopy (Scope)-Details: _____
- ☐ Back Surgery-Details: _____ _____
- ☐ Cardiac Surgery-Details: _____ _____
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Colectomy
- ☐ Colostomy
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ LASIK
- ☐ Meniscus Surgery
- ☐ Muscle Biopsy
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Female

- ☐ Cesarean Section
- ☐ Hysterectomy
- ☐ Mastectomy

Male

- ☐ Prostatectomy
- ☐ TURP
- ☐ Other: _____ _____ _____ _____

☐ **None**

PATIENT'S MEDICAL HISTORY

(Please circle all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hertrophy
- ☐ Cancer-Type: _____
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT (Blood Clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis-Type: _____
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Menopause-Date &/or Age: _____
- ☐ Migraine Disease
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ PVD
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Thyroid Disease
- ☐ Valvular Disease
- ☐ (Heart valve problems)
- ☐ Other: _____ _____ _____

☐ **None**

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ALLERGIES

(Please circle all in which you have an allergy & list the reaction-hives, nausea, anaphylaxis, etc)

Reaction:

- ☐ Aspirin _____
- ☐ Codeine _____
- ☐ IV Dye _____
- ☐ Latex _____
- ☐ **No Known Drug Allergies**

Reaction:

- ☐ NSAIDS _____
  (anti-inflammatories-ibuprofen, naprosyn)
- ☐ Narcotics _____
  (Percocet, Vicodin)
- ☐ Penicillin _____
- ☐ Sulfa _____

Allergy & Reaction:

Other _____

Other _____

Other _____

Other _____

MEDICATION LIST

Medication Name/Date Started	Dose	When Taken	Reason for Taking

Permission to view medication history (Please initial): _____

_____

Signature of Patient, Parent or Guardian Date