ORTHOPAEDIC SPECIALISTS OF AUSTIN

Name: _____ **Date of birth:** ____/____/____ **Age:** _____

Height: _____'_____" **Weight:** _____ lbs. **Shoe Size:** _____ ❑ Men ❑ Women

Referring Physician Name: _____

Please describe problem(s) you are here for today:_____

_____

How long have you had the problem? _____

If an injury, where did it occur? ❑ Home ❑ School ❑ Auto ❑ Other _____ Date of injury: ___/___/___

Describe pain: ❑ Sharp ❑ Aching ❑Stabbing Dull ❑ Cramping ❑ Throbbing Constant ❑ Pins and needles ❑ Intermittent

When does the pain occur? _____

What makes it worse? _____

What makes it better? _____

At each attribute, please mark the level you feel best describes your condition at the PRESENT time:

PAIN: ❑None ❑Slight (no change in activities) ❑Mild (Minimal change in activities) ❑Moderate ❑Severe (at night/rest)

❑Disabled

LIMP: ❑ None ❑ Slight ❑ Moderate ❑ Severe

WALKING DISTANCE: ❑ Unlimited ❑ 4-6 blocks ❑ 1-3 blocks ❑ Indoors only ❑ Unable to walk

WALKING AIDS: ❑ None ❑ Occasional Cane ❑ Cane ❑ Crutches/2 canes ❑ Walker ❑ Wheelchair

STAIR CLIMBING: ❑ Normal ❑ Need banister ❑ Needs aid more than banister ❑ Unable to climb stairs

WALKING SURFACE: ❑ Problems on uneven surfaces/hills ❑ Problems on all surfaces (even flat) ❑ Can walk anywhere

SHOES: ❑ Any type ❑ Minor limitations ❑ Flats only ❑ Need orthotics ❑ Custom shoes only ❑Unable to wear shoes

RUNNING: ❑ No limitations ❑ Slight limitation ❑ Moderate limitation ❑ Unable to run

DIABETES: ❑Yes ❑ No Date of Diagnosis: ___/___/___

ATHLETIC ACTIVITIES: (Describe) _____

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Medical History *Check the boxes that correspond to diagnoses you have been given in the past*					
ADD/ADHD		Diabetes mellitus		Inflammatory bowel disease	
Allergies		Eating disorder		Liver disorder	
Anemia		Emphysema		Nerve/muscle disease	
Anxiety		Genitourinary Disease		Obesity	
Arthritis		GERD		Osteoporosis	
Asthma		Glaucoma		Pneumonia	
Bleeding Disorder		Headaches		Seizures	
Cancer		Hearing Loss		Skin Disease	
Congestive Heart Failure		Heart Disease		Stroke	
COPD		Hepatitis		Substance Abuse	
Coronary Artery Disease		HIV/AIDS		Thyroid Disease	
Dementia		Hyperlipidemia		Ulcers (GI)	
Depression		Hypertension		Vision Problems	

Surgical History *Check the boxes that correspond to surgeries you have had in the past*					
Abdomen Surgery		Eye Surgery		Spine Surgery	
Adenoidectomy		Gallbladder Surgery		Stent	
Appendectomy		Heart Surgery		Tonsillectomy	
Breast Surgery		Hernia Repair		Tubal Ligation	
CABG (Bypass Surgery)		Hysterectomy		Upper GI Endoscopy	
Colonoscopy		Joint Replacement		Valve Replacement	
Cosmetic Surgery		Orthopedic Surgery		Weight Loss Surgery	
C-Section		Sinus Surgery			

Family History *Check the boxes that correspond to your family history* ◯ Adopted

	Arthritis	Asthma	Cancer	Depression	Diabetes	Early Death	Heart Disease	High Cholesterol	Hypertension	Stroke
Mother										
Father										
Sister										
Brother										
Grandfather										
Grandmother										

Medications *List your medication name, strength and frequency*

Name of Drug	Strength	Frequency	Name of Drug	Strength	Frequency

Allergies ◯ NKDA *List your allergies and reactions.*

Medication Allergy	Reaction

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Social History	
Alcohol	Do you drink alcohol? ◯ Yes ◯ No If yes, how many drinks per week? _____
Tobacco	Do you use tobacco? ◯ Yes ◯ No
	◯ Cigarettes: ___ packs per day ◯ Dip: ___ # per day ◯ E-Cig/ Vape
	◯ Pipe: ___ # per week ◯ Cigars: ___ # per week
	How many years have you used tobacco? _____ What year did you quit? _____ ◯ Currently Smoking
Drugs	Do you currently use recreational or street drugs? ◯ Yes ◯ No
	If yes, what kind?

Review of Systems *Check the boxes that correspond to any symptoms you are **CURRENTLY** experiencing.*

CONSTITUTIONAL		CARDIOVASCULAR		ALLERGY / IMMUNO	
Fever		Chest pain		Environmental Allergies	
Unexpected weight change		Palpitations		Food Allergies	
HENT		SKIN		Immunocompromised	
Congestion		Rash		NEUROLOGICAL	
Ear pain		Wound		Dizziness	
GI		ENDOCRINE		Headaches	
Constipation		Cold Intolerance		Numbness	
Diarrhea		Heat Intolerance		Weakness	
Nausea		GU		HEMATOLOGIC	
EYES		Painful urination (Dysuria)		Large lymph nodes (adenopathy)	
Eye pain		Frequent urination		Bruises / Bleeds easily	
Sensitivity to light		MUSCULOSKELETAL		PSYCHIATRIC	
RESPIRATORY		Painful Joint (Arthralgia)		Hallucinations	
Cough		Back pain		Nervous / Anxious	
Shortness of breath		Joint swelling		Suicidal ideas	