CALIFORNIA ORTHOPAEDIC SPECIALISTS

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PATIENT INFORMATION DATA

DATE_____

NAME_____

AGE_____HEIGHT_____WEIGHT_____

DOMINANCE: RIGHT: _____ LEFT: _____ AMBIDEXTROUS: _____

PRESENT HISTORY: *CHECK CORRECT ITEM OR FILL IN THE BLANKS*

MY PRESENT PROBLEM IS WITH MY: RIGHT _____ LEFT _____

_____KNEE _____SHOULDER _____ELBOW _____WRIST _____HIP

_____FOOT/TOES _____ANKLE _____HAND/FINGERS _____OTHER

WHEN DID THE PRESENT PROBLEM START? _____

HAS BEEN WORSENING SINCE? _____

THE PROBLEM BEGAN: _____GRADUALLY _____SUDDENLY

THE PROBLEM BEGAN AT HOME_____

AT WORK_____

WITH AN ACCIDENT_____

THE PROBLEM BEGAN: _____ WHEN I FELL _____ AT THE TIME OF THE ACCIDENT

_____DURING OR AFTER LIFTING/BENDING _____FOR NO APPARENT REASON

ACCIDENT/INJURY DATA:

DATE_____

LOCATION _____

SPECIFICS _____

_____

MEDICAL ATTENTION _____

_____

IF MVA: SEAT BELT / SHOULDER HARNESS: _____ON _____OFF

PRESENT COMPLAINTS:

DO YOU HAVE PAIN? _____YES _____NO

WHERE?_____

IS YOUR PAIN: _____CONSTANT _____DULL _____ACHING _____STABBING _____BURNING

DO YOU HAVE RADIATING PAIN? _____

DO YOU HAVE NUMBNESS OR TINGLING? _____

DO YOU HAVE ANY WEAKNESS? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT MAKES YOUR PAIN BETTER? _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS: _____STIFFNESS _____SPASMS

_____SWELLING _____GRINDING _____LOCKING _____GIVING WAY _____POPPING

_____UNABLE TO BEND OR FLEX YOUR JOINT _____OTHER_____

WHAT TREATMENT HAVE YOU USED? (i.e., heat, ice, medicine):_____

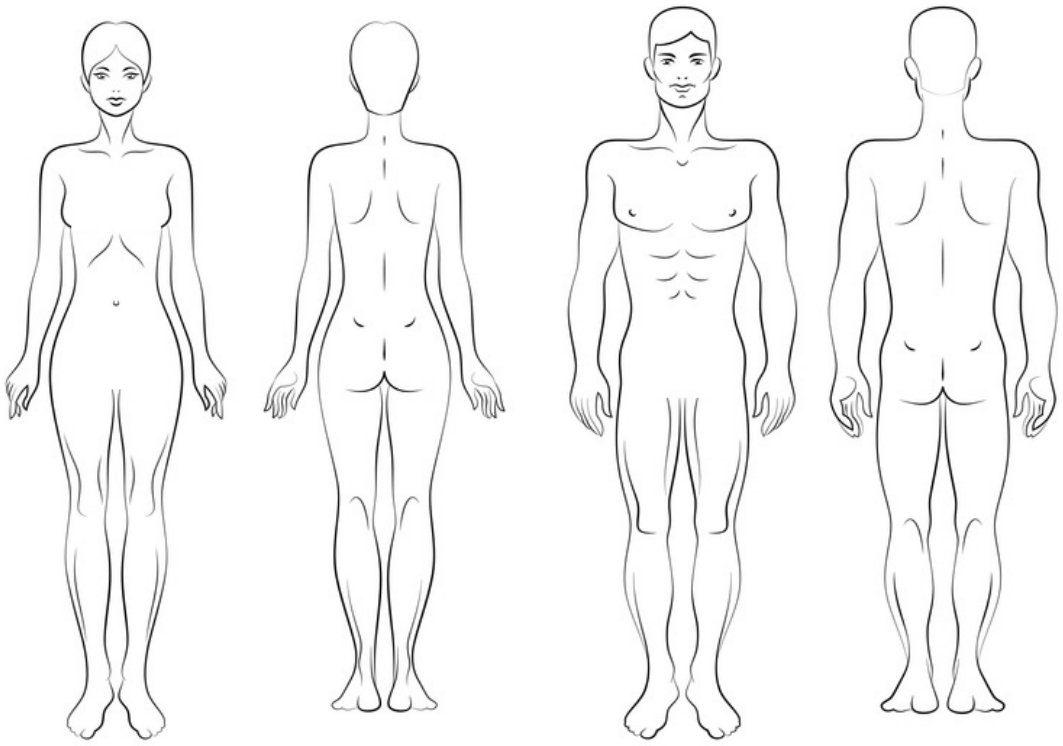
HAVE YOU EVER HAD AN INJURY OR SIMILAR SYMPTOMS TO THE SAME AREA OF YOUR BODY

PRIOR TO THIS ILLNESS/INJURY _____YES _____NO

IF YES, EXPLAIN:

PAIN DRAWING:

MARK AREAS ON THE FOLLOWING DRAWINGS WHERE YOUR PAIN IS:



MEDICAL HISTORY

ALLERGIES (food or medication)
(Include type of reaction)

_____
_____

List any medications you take regularly or occasionally:

NAME **DOSE** **HOW OFTEN**

_____
_____
_____
_____

Do you have any medical problems? _____YES _____NO

If yes, please circle and give brief description.

Heart
Lungs
Seizures
Kidneys, bladder
Depression
Bleeding tendencies
Tendencies for infection
Exposure to hepatitis
Exposure to HIV infection (AIDS)
Exposure to TB infection

Did you have the usual childhood diseases? (measles, mumps, chicken pox) ___Yes ___No

Have you ever used recreational drugs? _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD:

DATE **OPERATION** **ANY COMPLICATIONS**

_____
_____
_____
_____

Do you smoke: ____Yes ____No Packs/day _____for _____years

Alcohol: ____Yes ____No How much?_____

Caffeine: ___Yes ___No ___Coffee ___Tea ___Soda Cups/cans per day_____

Do you have an attorney who will want a report about this exam? ____Yes ____No

If yes:

Name_____

Address_____

EMPLOYMENT HISTORY

Present Employer: _____
How Long: _____
Present job/occupation: _____

My present/last job involves(d): (Check all that apply)

	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Lifting	_____lbs.	_____ lbs.	_____ lbs.
Bending	_____	_____	_____
Twisting	_____	_____	_____
Sitting	_____ hrs.	_____ hrs.	_____ hrs.
Standing	_____ hrs.	_____ hrs.	_____ hrs.
Walking	_____ hrs.	_____ _hrs.	_____ hrs.
Driving	_____ hrs.	_____ hrs.	_____ hrs.

IF UNEMPLOYED OR NOT CURRENTLY WORKING:

Retired: ___Yes ___No

On medical leave: ___Yes ___No Since: _____

Laid off: ___Yes ___No Since: _____

On total disability: ___Yes ___No Since: _____

SSD: ___Yes ___No Next review: _____

I last worked on: _____

My employer would allow me to return to work with restrictions: ___Yes ___No

ACTIVITIES

What sports-related, physical activities or hobbies to you engage in?

Aerobics_____
Step aerobics_____
Walking_____
Golf_____
Tennis_____
Baseball_____
Track_____
Jogging_____
Swimming_____
Bicycle riding_____
Karate_____
Volleyball_____
Basketball_____
Football_____
Other_____
_____

Have you been limited in these activities?
Yes___ No___ How? _____

Other activities in which you have participated:

Dancing_____ Gardening_____
Yard work_____ Carpentry_____
Other_____ _____