

NAME:		Age:		Date:	
<b>Chief Complaint</b>					
1. For what problem are you seeing the doctor today?					
<b>History of Present Illness</b>					
When did your problem, injury or pain begin?					
Is this a work-related injury or illness? <input type="checkbox"/> YES <input type="checkbox"/> NO			If yes, You MUST provide workers compensation information to Orthopedics & Sports Medicine of SF		
Were you seen in the Emergency Room?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date:	
How did your problem start? (Please check all that apply.)	Suddenly <input type="checkbox"/>	During sports <input type="checkbox"/>	Fall <input type="checkbox"/>	Lifting <input type="checkbox"/>	Auto Accident <input type="checkbox"/>
	Over time <input type="checkbox"/>	At work <input type="checkbox"/>	Twisting <input type="checkbox"/>	Pulling <input type="checkbox"/>	No apparent cause <input type="checkbox"/>
Other (describe):					
What are your symptoms? (Please check all that apply.)	Pain <input type="checkbox"/>	Swelling <input type="checkbox"/>	Redness <input type="checkbox"/>	Bruising <input type="checkbox"/>	Spasm <input type="checkbox"/>
	Tingling <input type="checkbox"/>	Locking <input type="checkbox"/>	Catching <input type="checkbox"/>	Giving Way <input type="checkbox"/>	Weakness <input type="checkbox"/>
If you have pain, how would you describe it? (Please check all that apply.)	Constant <input type="checkbox"/>		Intermittent <input type="checkbox"/>		While at rest <input type="checkbox"/>
	With Activity <input type="checkbox"/>		Burning <input type="checkbox"/>		Aching <input type="checkbox"/>
On average, how severe is your pain?	1	2	3	4	5
	No Pain		6	7	8
What reduces your symptoms? (Please check all that apply.)	Sitting <input type="checkbox"/>		Lying down <input type="checkbox"/>		Standing <input type="checkbox"/>
	Walking <input type="checkbox"/>		Medication <input type="checkbox"/>		Physical Therapy <input type="checkbox"/>
What makes your problem worse? (Please check all that apply.)	Sitting <input type="checkbox"/>		Standing <input type="checkbox"/>		Walking <input type="checkbox"/>
	Bending <input type="checkbox"/>		Exercise (during) <input type="checkbox"/>		Exercise (after) <input type="checkbox"/>
Have you had any diagnostic tests for this problem? (Please check all that apply.)	X-Rays <input type="checkbox"/>		CT scan <input type="checkbox"/>		MRI <input type="checkbox"/>
	Arthrogram (dye injection) <input type="checkbox"/>		Electromyogram (EMG) or Nerve Conduction Study (NCS) <input type="checkbox"/>		
Dates:	Place:		Delivered to OSMSF		With PT? <input type="checkbox"/>
<b>Have you or your family ever had any of the following conditions? (Please check all that apply.)</b>					
	Self	Family		Self	Family
Vision or hearing problems			Kidney disease/failure		
Thyroid problems			Diabetes		
Asthma or emphysema			Bone or joint problems		
High blood pressure			Arthritis or rheumatism		
Heart Problems			Gout		
Bleeding problems			Osteoporosis		
Blood Clots			Cancer		
Stomach Problems/ulcers/reflux			Skin Disorders		
Bowel or bladder problems			Seizures or epilepsy		
Are you allergic to any medications?			Please list medications causing allergic reactions:		
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Are you allergic to Latex?					
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Women Only: Are you, or could you be, pregnant?			Due Date?		Last menstrual period?
<input type="checkbox"/> YES <input type="checkbox"/> NO					

**REVIEW OF SYSTEMS: Are you currently experience any of the following? (Please check all that apply.)**

	Yes	No
General: weight change, fatigue, fever, chills, night sweats.		
Skin: itching, rashes, sores, lumps,		
HEENT: headaches, visual changes, hearing loss, dizziness, earaches, allergy, sore throat,		
Respiratory: shortness of breath, cough, asthma,		
Cardiac: high blood pressure, chest pain/pressure, irregular heart beat		
GI: nausea, vomiting, constipation, abdominal pain		
Urinary: burning or pain on urination, kidney stones, urinary tract infection, frequency of urination		
Vascular: swelling in the legs, history of blood clots, varicose veins		
Musculoskeletal: muscle weakness, pain, joint stiffness, instability, redness, swelling, arthritis, gout		
Neurologic: loss of consciousness/fainting, numbness, tingling, tremors, weakness/paralysis		
Hematologic: easy bruising, bleeding problems, anemia		
Endocrine: heat/cold intolerance, excessive sweating, thyroid problems, diabetes		

**Past Medical History**

**Please list ALL previous major surgeries, bone and joint surgeries and/or broken bones:**

Surgery	Date	Surgery	Date

**Social History**

What is/was your occupation?		Employer:	
Do/did you use tobacco? Yes No	Type of tobacco?	How much?	Quit when?
Do you drink alcoholic beverages? Yes No		How many drinks per day?	
Do you use prescription pain medication or "street" drugs? Yes No		Which?	
Have you ever been addicted to prescription or non-prescription drugs? Yes No		Which?	
Do you live alone? Yes No	How often do you exercise?	Never Rarely	Daily Weekly Monthly
	What type of exercise?		

**Miscellaneous**

Were you referred here by a physician? Yes No	Physician Name:
Who is your primary care physician?	Is there any legal action pending that pertains to your visit?

**For Office Use Only**

Height	Weight	Pulse	Blood Pressure	Respirations	Reviewed by	Date

Patient label here