

Saint Louis-Clayton Orthopedic Group

_____ ()
First Name **Last Name** **Date of Birth (Age)**

Primary Care MD **Referred By** **Employer**

Height ___ feet ___ Inches **Weight** _____ lbs **I am:**

What are you being seen for today (what body part)?

Which Side?

- How long has this been going on? _____
- Is this related to an injury? _____
- Where you hurt at work? _____
- Are you currently working? _____

If you are limited duty, how long? _____

Describe how your problem or pain started:

Rate the Pain:
None
Mild
Moderate
Severe

Describe you pain: (check all that apply)

Shooting	Intermittent
Stabbing	Constant
Sharp	Achy
Dull	Worse at night

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Do you have any other problems? (check all that apply)

Numbness	Buckling	Redness	Locking
Tingling	Weakness	Bruising	Catching
Popping	Drainage	Swelling	Grinding
Giving Way	Discharge	Discoloration	

Do any of the following improve your symptoms? (check all that apply)

Sitting	Bracing
Standing	Wrapping with Ace
Lying Down	Ice
Heat	Elevation

Do any of the following worsen your symptoms? (check all that apply)

Sitting	Walking
Standing	Throwing
Lying Down	Squatting
Going down stairs	Kneeling

Past Medical History.

Do you have or have you had any of the following? Please check all that apply:

Stroke	Tuberculosis	Rheumatoid Arthritis	Cancer
Heart Attack	Inflammatory Bowel Dz	Polio	Osteoarthritis
High Blood Pressure	Seizures	HIV or AIDS	Currently Pregnant
Heart Valve Disease	Asthma	Diabetes	
Heart Rhythm Problems	Urinary Tract Infections	Hypothyroidism	
Stomach Ulcers	Mental Illness	Hyperthyroidism	
Kidney Disease	Alcoholism	Low Back Pain	
Hepatitis	Depression	Blood Transfusions	
Neuropathy	Anxiety	Bleeding Disorder	
COPD	Anemia	Blood Clots	
Lung Disease	Gout	Bronchitis	

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Please explain any of those you have checked:

Past Surgical History

Please list any previous surgeries, including date and physician:

Medications and Allergies

List any and all medications you take:

List medications to which you are allergic or cannot take. Please describe the reaction:

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Family History

Please check any problems that run in your family and indicate in whom:

Stroke	Mental Illness
Heart Attack	HIV or AIDS
High Blood Pressure	Bleeding Disorder
Heart Valve Disease	Blood Clots
Diabetes	Alcoholism
Kidney Disease	Cancer (what kind, in whom?)
Lung Disease	
Tuberculosis	Osteoarthritis
Heart Rhythm Problems	Gout

Social History:

Work Status: Working Unemployed Retired Disabled Student Homemaker

Occupation (current or most recent): _____

Marital Status: Married Divorced Separated Single Widow

Tobacco Use: Never Cigarettes Cigar Pipe Chew

Cigarettes: _____ packs a day for _____ years

Quit? When? _____ after smoking _____ packs a day for _____ years

Alcohol Use: Never Rare Social Alcoholic Recovering Alcoholic

Drug Use: Never Currently In the Past

Review of Systems:

Fevers	Intolerance to Stairs	Urinary Frequency	Weight Gain
Chills	Heart Palpitations	Painful Urination	Difficulty Swallowing
Nausea	Heartburn	Swollen Legs	Difficulty Hearing
Vomiting	Stomach Pain	Calf Cramps	Runny Nose
Headaches	Dark, Tarry Stools	Poor Appetite	
Dizziness	Blood in Stools	Claustrophobia	
Lightheadedness	Wheezing	Metallic Implants	
Visual Changes	Diarrhea	Metal in Eyes	
Chest Pain	Constipation	Depression	
Shortness of Breath	Urinary Retention	Weight Loss	