The difference is personal
Coastal ORTHO
Orthopedics · Rehabilitation · Sports Medicine

Chief Complaint

Dominant hand:

☐ Right hand ☐ Left Hand ☐ Ambidextrous

Description of the symptoms (select only one)

☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Weakness ☐ Swelling ☐ Stiffness Other: _____

Shoulder	☐ Right	☐ Left	Pelvis	☐ Right	☐ Left	Neck	☐	
Upper Arm	☐ Right	☐ Left	Hip	☐ Right	☐ Left	Upper Back	☐	
Elbow	☐ Right	☐ Left	Thigh	☐ Right	☐ Left	Mid Back	☐	
Forearm	☐ Right	☐ Left	Knee	☐ Right	☐ Left	Low Back	☐	
Wrist	☐ Right	☐ Left	Lower Leg	☐ Right	☐ Left	Buttocks	☐	
Hand	☐ Right	☐ Left	Ankle	☐ Right	☐ Left	Tail Bone	☐	
Thumb	☐ Right	☐ Left	Foot	☐ Right	☐ Left			
Index	☐ Right	☐ Left	Great Toe	☐ Right	☐ Left			
Middle	☐ Right	☐ Left	2nd Digit	☐ Right	☐ Left			
Third	☐ Right	☐ Left	3rd Digit	☐ Right	☐ Left			
Little	☐ Right	☐ Left	4th Digit	☐ Right	☐ Left			
			5th Digit	☐ Right	☐ Left			

History of Present Illness

How Long ago did the problem start? _____ Days _____ weeks _____ months _____ years

1. Is your problem the result of an injury or accident?

☐ No injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

Exact Date of Injury _____

Describe the Onset: ☐ Acute (Sudden) ☐ Chronic Condition (>3 months)

Onset Date: _____ (ex. mm/dd/yyyy)

2. Are you represented by an attorney? ☐ Yes ☐ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ☐ Yes ☐ No

3. Have you had a problem like this before? ☐ Yes ☐ No

Describe: _____

4. Have you been seen in ER for this problem? ☐ Yes ☐ No

If yes what ER: (ex.Mercy,CMMC,St. _____ Date: (mm/dd/yyyy) _____

Mary's)

5. Rate the pain (10 being the most pain).

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Do the symptoms wake you from sleep? ☐ Yes ☐ No

7. Please describe the symptoms.

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting

8. What is the timing of the symptoms?

☐ Constant ☐ Intermittent (comes & goes)

9. Is the problem getting better or worse?

☐ Getting better ☐ Getting worse ☐ Unchanged

10. What makes the symptoms worse?

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in Bed

☐ Running ☐ Walking ☐ Exercise ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead

☐ Coughing ☐ Sneezing

11. Are there any other symptoms associated to this problem:

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking

☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way

12. What makes your symptoms better

☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other

Prior Treatment / Testing

Have you had any prior tests for this problem?

☐ None ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG) ☐ Ultrasound

Where? When?

Have you had any prior treatments for this problem? ☐ Yes ☐ No

Type of treatment:	Status of symptoms after treatment (Select only those that apply):	Date treatment was received:
Cane / Crutch	☐ Improved ☐ Worsened ☐ Unchanged	
Ice	☐ Improved ☐ Worsened ☐ Unchanged	
Heat		

	☐ Improved ☐ Worsened ☐ Unchanged	
Rest	☐ Improved ☐ Worsened ☐ Unchanged	
NSAIDs	☐ Improved ☐ Worsened ☐ Unchanged	
Muscle Relaxers	☐ Improved ☐ Worsened ☐ Unchanged	
Chiropractor	☐ Improved ☐ Worsened ☐ Unchanged	
Physical Therapy	☐ Improved ☐ Worsened ☐ Unchanged	
Home Exercise Program	☐ Improved ☐ Worsened ☐ Unchanged	
Surgery	☐ Improved ☐ Worsened ☐ Unchanged	
Injections	☐ Improved ☐ Worsened ☐ Unchanged	
Bracing	☐ Improved ☐ Worsened ☐ Unchanged	
Tens Unit	☐ Improved ☐ Worsened ☐ Unchanged	
Other/Comments:		

Past Surgical History

Select all previous hospitalizations/surgeries: ☐ **None**

☐ Aneurysm (Brain) Surgery
☐ Aortic Bypass / Vascular Surgery
☐ Appendectomy
☐ Cataract (Eye) Surgery
☐ Cholecystectomy (Gallbladder)
☐ Heart Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ LAP Band / Gastric Bypass Surgery
☐ Lumpectomy
☐ Mastectomy
☐ Malignancy / Cancer
☐ Stents

Orthopedic Surgery:	**Right**	**Left**
Arthroscopy: Knee	☐	☐
Arthroscopy: Shoulder	☐	☐
Carpal Tunnel Release	☐	☐
Rotator Cuff Repair	☐	☐
Total Hip Replacement	☐	☐
Total Knee Replacement	☐	☐
Total Shoulder Replacement	☐	☐
Spinal Surgery - Indicate Level:		

Other Surgery:

Other Orthopedic Surgery:

Medical Questions

Mark all that currently apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Use a C PAP ☐ Snores

Are you taking blood thinners? ☐ **Yes** ☐ **No**

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months? ☐ None for all

						Comments **NONE**
1) GI	☐ Heartburn, Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐ Hepatitis	☐ Liver Disease	☐
2) ENDO	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats	☐ Thyroid Disease		☐
3) CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue			☐
4) EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss			☐
5) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing			☐
6) CARDIO	☐ Chest Pain	☐ Palpitations				☐
			☐ Shortness of			

7) LUNGS	☐ Chronic Cough	☐ Pneumonia	Breath			☐
8) GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems			☐
9) SKIN	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis			☐
10) NEURO	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness	☐ Headaches	☐ Seizures	☐
	☐ Change in bowel	☐ Change in bladder	☐ Dizziness			
11) PSYCH	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder			☐
12) HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐ Blood Clots	☐ Musc/Skel	☐
	☐ Diabeties					

FAMILY HISTORY

Have any direct relatives had any of the following disorders? ☐ None for all

Father:

☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer

Comments:

Mother:

☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer

Comments:

Sibling:

☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer

Comments:

SOCIAL HISTORY

1. Do you smoke tobacco? ☐ Yes ☐ No ☐ Former Smoker ☐ Never ☐ Unknown Other tobacco products

2. Do you drink alcohol? ☐ Daily How Much ☐ Social ☐ Rarely ☐ Never

3. Marital History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

4. Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled

If no, what date did you last work? (ex. mm/dd/yyyy)

Please list work restrictions, if any: (ex. Lifting, Prolonged Sitting, etc.)

Occupation / Job Description:

Employer:

☐ **Student (If yes)**

School

Grade

Sports

Medical Information Tab

Please list any allergies to Medication, Foods, or Seasonal: ☐ NONE

Latex Allergy? ☐

Anesthesia Allergy? ☐

Please list all medications you take on a regular basis: ☐ NONE

Do you have a personal history of any of the following? ☐ NONE

☐ Aneurysm - Where:	☐ Emphysema	☐ Kidney Disease
☐ Angina (chest pain)	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis - Type:	☐ Heart Attack	☐ MRSA Infection
☐ Asthma	☐ Hepatitis - Type:	☐ Pacemaker
☐ Bone or Joint Infections	☐ HIV/AIDS	☐ Phlebitis (Blood Clots)
☐ Cancer - Type:	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Chemotherapy/Radiation	☐ Hypertension	☐ Reaction to Anesthesia - Type:
☐ COPD	☐ Hyperthyroidism	☐ Seizures
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Stomach Problems
☐ Diabetes - Type:	Last A1C	☐ Stroke / TIA
☐ Heat Failure		☐ Tuberculosis

Other:

Patient / Guardian Signature : _____