BONE & JOINT SURGEONS, INC.
Orthopedic Surgeons

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Date____/_______/_________ I have an appointment with Dr. ______________________________

Patient's Name____________________________________☐ Male ☐ Female Date of Birth______________
(Last) (First) (MI)

Address________________________________City____________________ST_____ZIP___________

Home Phone________________ Cell Phone____________________e-mail ___________________________

SS#_____________________________ Marital Status: M☐ S☐ W☐ D☐

Emergency Contact____________________Relationship______________Home #__________Cell #__________

Primary Care Physician______________________________________Date of last visit______/______/_________

Referring MD________________________________

Preferred Pharmacy_______________________________________City____________________________

EMPLOYMENT INFORMATION

Employer: ____ ☐ Full time ☐Part time

Occupation_________________________ Work #____________________ Student Y☐ N☐ ☐Full time ☐Part time

Spouse Name__________________________ Spouse Employer______________________ Phone ____________

MEDICAL INFORMATION

Reason for visit ____ Left ☐ Right☐ Bilateral ☐

When did symptoms start ______/______/________ If injury, Date of Injury ______/______/________

If an injury, how did injury occur? ____

Work related? Y☐ N☐ Accident Related? Y☐ N☐ Auto Accident? Y☐ N☐ Gradual onset Y☐ N☐ Sudden onset Y☐ N☐

Have you been treated by another physician for this problem? Y☐ N☐

If yes, please explain (Name of physician and date of treatment) ____

Have you ever been treated by another orthopedic / podiatric surgeon? Y☐ N☐

If yes, please explain (Name of physician and date of treatment) ____

MEDICAL INFORMATION

I consider my health ☐ Good ☐ Fair ☐ Poor

I have pain... constantly ☐ intermittently ☐ daily ☐ weekly ☐ rarely ☐

At best my pain is ______ out of 10 At worst ______ out of 10 (0 no pain ---10 worst pain you've ever had)

The pain is (check all that apply) dull ☐ sharp ☐ stabbing ☐ burning ☐ throbbing ☐ radiates down arm/leg ☐

Previous treatments: check all that apply. Please note those that did or didn't help.
Medications:

☐ Ibuprofen (Motrin, Advil) Helped ☐ Didn't help ☐
☐ Aleve (Naprosyn) Helped ☐ Didn't help ☐
☐ Tylenol Helped ☐ Didn't help ☐
☐ Ultram (Tramadol) Helped ☐ Didn't help ☐
☐ Narcotics (Lortab, Hydrocodone, Percocet, Oxycodone, Morphine) Helped ☐ Didn't help ☐
☐ Lyrica Helped ☐ Didn't help ☐
☐ Neurontin Helped ☐ Didn't help ☐
☐ Other ______________________________ Helped ☐ Didn't help ☐

Have you tried Physical Therapy? Y ☐ N ☐ How much? ______________________________

Injections? Cortisone Y ☐ N ☐ Synvisc Y ☐ N ☐ Hyalgan Y ☐ N ☐ Platelet Rich Plasma Y ☐ N ☐

I have trouble with: (check all that apply)

☐ Sleeping
☐ Reaching overhead
☐ Combing my hair
☐ Lifting objects
☐ Putting on pants/socks/shoes
☐ Getting in/out of car
☐ Pivoting
☐ Knee locking
☐ Knee catching
☐ Knee gives away
☐ Popping or grinding
☐ Going up stairs
☐ Going down stairs
☐ Driving
☐ Squatting
☐ Standing
☐ Running
☐ Swelling
☐ Redness
☐ Doing housework
☐ Other ______________________________

How far can you walk without assistance or having to stop for a break?

☐ < 50 ft. ☐ 50-100 ft. ☐ 100-500 ft. ☐ 500-1000 ft. ☐ ½ mile ☐ 1 mile ☐ unlimited

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I have or have had: (Please check/circle all that apply)

☐ High blood pressure
☐ Heart Attack
☐ Congestive Heart Failure
☐ Anemia/Unusual Bleeding
☐ Anxiety/Depression
☐ Asthma/Emphysema/Black Lung
☐ Thyroid Disease
☐ Ulcer/Reflux
☐ Hepatitis/Jaundice
☐ Kidney/Bladder/Prostate Disease
☐ Diabetes – Insulin ☐ Yes ☐ No
☐ Cancer – Where?______________
☐ Blood Clots? – Where?________
☐ Drug Dependency
☐ Stroke/Seizures
☐ Other____________________________

PAST MEDICAL AND SURGICAL HISTORY

Patient Name ______________________________________**Height** ______________ **Weight** _______________

Medications (please include over the counter meds, supplements, vitamins) See list ☐

____

____

____

____

____

____

____

Allergies (Please include reaction)

____

____

____

Are you allergic to?: Latex Y ☐ N ☐ Penicillin Y ☐ N ☐ Sulfa Y ☐ N ☐ Cortisone Y ☐ N ☐ Steroids Y ☐ N ☐ Chicken Y ☐ N ☐ Eggs Y ☐ N ☐
If yes, please list reaction: ____

Do you smoke? ☐ Yes ☐ No How much? _____ How long? ____ **Do you drink alcohol?** ☐ Yes ☐ No How much? ______

Previous surgeries (type & year):____

____

____

____

____

Are you pregnant? ☐ Yes ☐ No Any previous problems with anesthesia? ☐ Yes ☐ No

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I have or recently have had: (Please check/circle all that apply)

☐ Fever/Chills	☐ Chest Pain	☐ Rectal Bleeding	☐ Skin Rashes/Skin Ulcers
☐ Cold/Flu symptoms	☐ Heart Irregularity	☐ Dark or Black Stool	☐ Recent Hair Loss
☐ Headaches	☐ Leg/Ankle Swelling	☐ Change in Bowel Habits	☐ Unplanned Weight Loss
☐ Blurred Vision	☐ Coughing Up Blood	☐ Burning with Urination	☐ Generalized Weakness
☐ Recent Vision Change	☐ Shortness of Breath	☐ Frequent Urination	☐ Depression
☐ Frequent Nose Bleeds	☐ Heartburn/Indigestion	☐ Menstrual Irregularity	☐ Loss of Appetite
☐ Hoarseness	☐ Nausea/Vomiting	☐ Vaginal Bleeding	☐ Other_____________________
☐ Hearing Loss	☐ Abdominal Pain		

Family History

Do you have a family history of: (Please check/circle all that apply)

☐ Heart disease ☐ Seizures ☐ Diabetes ☐ Stroke ☐ Kidney disease ☐ Thyroid disorder ☐ Cancer, what type_________