Advanced Orthopedics and Sports Medicine Institute, PC

A CENTER OF EXCELLENCE FOR BONE AND JOINT CARE

Name: ____________________________

What is you main complaint today? ____________________________

Please describe the pain:

Quality (burning/stabbing, etc.)____________________________

Severity (rank 1-10 or describe – "severe/slight/worst I have ever had") ____________________________

Duration (how long pain lasts when present) ____________________________

Timing (when does pain occur – night/with activity/intermittent etc.) ____________________________

Context (situation associated with the pain) ____________________________

Modifying Factors (what increases/decrease pain – ice/rest/etc.) ____________________________

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Associated signs/symptoms (i.e. back pain causes leg pain, knee pain causes giving way etc.) ____________________________

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When did your problem start (exact date if possible): ____________________________

What caused your problem to start?____________________________

Detail your progress to date: ____________________________

Is this problem: Resulting from an accident? ◊ Yes ◊ No Work Related? ◊ Yes ◊ No

Involving Litigation ◊ Yes ◊ No

Detail your treatments to date:

Physical Therapy: ____________________________

Injections: ____________________________

Other: ____________________________

Have X-rays been taken? __________ When? __________ MRIs? __________ When? __________

Have CAT scans been taken? ______ When? __________ Bone Scans? ______ When? __________

Female: Date of last menstrual period ____________________ Date of Menopause ____________________

Drug Allergies: ◊ Penicillin Reaction ________________ ◊ Sulfa drugs Reaction ________________

◊ Other (list) ____________________ Reaction ____________________

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Check if you are having or have ever had a problem with any of the following:

◊ High Blood Pressure ◊ Diabetes ◊ Asthma ◊ Ulcers ◊ Phlebitis ◊ Thyroid Disorder

◊ Rheumatologic diseases ◊ Cancer ◊ Hepatitis ◊ Blood diseases ◊ Cholesterol ◊ Epilepsy/seizures

List any extra details from above (or other medical problems): ____________________________

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PLEASE COMPLETE THESE FORMS TO THE BEST OF YOUR ABILITY.
THIS INFORMATION WILL ASSIST YOUR PHYSICIAN IN YOUR TREATMENT.

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