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.) _____

_____

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

_____

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 _____
◊ Other (list) _____ Reaction _____

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): _____

_____

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

POND VIEW PROFESSIONAL PARK
1101 WEST MAIN STREET • BLDG. 300 • SUITE 100 • FREEHOLD, NJ 07728 • PHONE: 732-720-2555 • FAX: 732-720-2556
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Name: _____

Past Surgical History (include all operations):

	Type	*Approximate Year*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Any previous fractures? ◊ Yes ◊ No Describe _____

Any other serious injuries? ◊ Yes ◊ No Describe _____

List *all medications* currently being taken and explain what each medication is for (include over the counter medications, vitamins, cartilage supplements and birth control pills):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Social History

What is your approximate height? _____ Weight _____ Shoe Size_____

Do you smoke? ◊ Yes ◊ No ◊ Past How much? _____

Do you drink? ◊ Yes ◊ No ◊ Past How much? _____

Have you ever had a problem with drugs? ◊ Yes ◊ No Describe _____

Do you exercise regularly (how much)? _____

What is your occupation? _____

Are you married, single, divorced, etc.? _____

Are you ◊ right handed ◊ left handed

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Name: _____

Family history – List any illnesses that run in your family

Problem	*Family Member(s)*
◊ Cancer	_____
◊ Heart disease	_____
◊ Diabetes	_____
◊ Rheumatoid arthritis	_____
◊ Osteoarthritis	_____
◊ Bleeding problems	_____
◊ Gout	_____
◊ Anesthesia problems	_____
◊ Other (List)_____	_____

Any other important details left out, please list here: _____

_____

I have reviewed this information with the patient. MD Signature:_____ Date: _____

I have reviewed and updated this information with the patient. MD Signature:_____ Date: _____

I have reviewed and updated this information with the patient. MD Signature:_____ Date: _____

I have reviewed and updated this information with the patient. MD Signature:_____ Date: _____

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