ORTHOPEDIC EVALUATION

Please list or explain the primary reason for your visit today. (We generally evaluate one problem per appointment.)

____

____

MEDICAL HISTORY

(Please circle all that apply)

Cardiovascular Disease

Heart Attack
High Blood Pressure
Artificial Heart Valve
Pacemaker
Coronary Bypass Surgery
Poor Circulation
Heart Murmur
Rheumatic Fever

Lung Disease

Asthma
Emphysema
Cough
Shortness of Breath
Lung Surgery
Sleep Apnea
Snoring
CPAP

Digestive Disease

Ulcers/Reflux
Gall Stones
Chronic Diarrhea
Hepatitis
Stomach Pain Liver
Disease Abdominal
Surgery
Bowel Control Problems

Systemic Disease

Diabetes
Thyroid Disease
Kidney Failure
AIDS /HIV
Recent Weight Loss
Cancer
Night Sweats
MRSA Carrier

Orthopedic Problems

Neck Pain or Surgery
Shoulder Pain or Surgery
Elbow Pain or Surgery
Wrist Pain or Surgery
Hand Pain or Surgery
Scoliosis Surgery
Upper Back Pain
Lower Back Pain
Lumbar Spine Surgery
Hip Pain or Surgery
Knee Pain or Surgery
Ankle Pain or Surgery
Foot Pain or Surgery

Neurological Disease

Epilepsy / Seizure
Stroke / TIA
Multiple Sclerosis
Neuropathy
Nerve Damage

Hematologic Disease

Blood Clots
Anemia
Hemophilia
Leukemia
Coumadin Use
Plavix Use

Psychological

Psychiatric Care
Nervous Problems
Depression / Anxiety
Bipolar Illness
Psychosis
Drug Dependency
Drug Abuse
Alcoholism

Genitourinary Disease

Bladder Control Problems
Bladder Infections
Kidney Infections
Kidney Stones
Sexually Transmitted Diseases

Past Surgery

Gallbladder
Appendix
Hysterectomy
Breast Surgery
Thyroid Surgery
Bladder Surgery
Stomach/Bowl Surgery
Kidney Surgery
Other ____________________

CURRENT AND RECENT MEDICATIONS:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

ALLERGIES:

____

____

____

____

NAME ____

CHART # ____________________________