Parkview Orthopedics and Sports Specialists

Name: ____Height:______ Weight______ Today's Date: ___________

Reason for Visit:____ Provider Seeing You Today :__________________

If problem is an injury was it at ☐ Work ☐ Auto Accident ☐ Other Date Problem Started: ___________

What does your problem limit you from doing?____

What makes the pain/symptoms ***worse***?____

Pain (0-None 10- Severe): **0 1 2 3 4 5 6 7 8 9 10**

Quality of Pain(Circle all that apply): Shooting/ Stabbing/ Burning/ Throbbing/ Aching/ Sharp/ Constant/ Intermittent

Previous treatment for this problem (if any): ☐ Rest/Ice/Heat ☐ Splint/Brace ☐ Injection ☐ Walker/Cane ☐ Therapy
☐ Anti-inflammatory(Ibuprofen, Naproxen, etc) ☐ Prescription Medication:________________________
☐ Emergency Room (If so) Date: ___/____/____☐ Other Medical Provider(s):_________________ Other: __________

Did the treatment (if any) help? **Yes No** If so, what helped and how long:___________________________________

Have you had surgery for this problem? Yes No If yes, when was surgery:_______________________________

For this problem, have you had imaging? Circle all that apply. None X-Rays MRI CT
If yes , where?____

MEDICATIONS: Please attach list if needed		
Prescription & non-prescription	**Dose & frequency**	**Reason**
1.		
2.		
3.		
4.		
5.		

ALLERGIES: Medicine or other? ☐ NONE	
Substance	Reaction
1.	
2.	
3.	
4.	

Reaction to anesthesia? ☐ Yes ☐ No
If yes, describe:_______________________

MEDICAL HISTORY					
Have you had/have any of the following conditions? Please Circle Yes(**Y**) or No(**N**).					
Diabetes	**Y / N**	Seizure/Epilepsy	**Y / N**	Heart Disease/Heart Attack	**Y / N**
High Blood Pressure	**Y / N**	Sleep Apnea	**Y / N**	Stomach/Intestine problems	**Y / N**
Blood Clot	**Y / N**	COPD/Asthma	**Y / N**	Arthritis	**Y / N**
Bleeding Problem	**Y / N**	Kidney Disease	**Y / N**	Urinary Problems	**Y / N**
Liver Disease/Hepatitis	**Y / N**	Thyroid Problem	**Y / N**	Depression/Anxiety/Mental Health	**Y / N**
Autoimmune Disease	**Y / N**	Cancer	**Y / N**	Alcohol/Substance Abuse	**Y / N**
Please explain above listed medical problems and others, if not listed:					

Turn Over & Complete Back

Month/Year	PLEASE LIST SURGERIES:
1.	
2.	
3.	
4.	

Month/Year	Hospitalization Reason
1.	
2.	
3.	
4.	

FAMILY HISTORY: Indicate if any immediate blood relative has had the following (Please specify parent, sibling, child in space)		
Bleeding Disorder/Clots: **Y / N**________	Depression/Suicide: **Y / N** _________	Asthma/COPD: **Y / N** _____________
Diabetes: **Y / N** ____________________	Genetic disorders: **Y / N** ___________	Liver Disease: **Y / N** ______________
Heart disease: **Y / N** ________________	High blood Pressure: **Y / N** _________	Kidney Disease: **Y / N** ____________
Anesthesia Problem: **Y / N** ___________	Cancer (type): **Y / N** _______________	Other:

SOCIAL HISTORY	**Dominant hand: ☐ Right ☐ Left ☐ Both**
Occupation/Job description:	If disabled, when did you last work?
Have you ever used tobacco? ☐ Yes ☐ No If yes, what type? ☐ Cigarette ☐ Pipe/Cigar ☐ Snuff/Chew Amount per day: ___________________________ How many years?__________________ ☐ Use Tobacco Currently ☐ Quit ____________ years ago ☐ Interested in Quitting	
Average alcohol intake in a week? Type of drinks: # of drinks/day:	
Recreational drug use: ☐Never ☐What and when:	
Family status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed # of Children (ages):	
Regular exercise? ☐No ☐Yes (type, frequency?)_________________________________ Hobbies:	

Patient Signature:_____________________________________ Date: _____/_____/_____

Provider Signature:____________________________________ Date: _____/_____/_____