Commonwealth Orthopedic Specialist, Inc.

Patient Name: _____ Date: _____

Home: _____Work/Cell: _____Email: _____

DOB: ____/_____/____ ☐**Male** ☐**Female** **Height: _____** **Weight: _____lbs**

Blood Pressure: _____/_____ **Shoe Size: _____** **Marital Status:_____**

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino ☐Unknown

Race: ☐White ☐Black/African American ☐Asian ☐American Indian ☐Alaskan Native
☐Native Hawaiian/Other Pacific Islander ☐Other: _____

Preferred Language: _____

Employment: ☐Unemployed ☐Retired ☐Student ☐Employed: _____

How did you hear about our practice?

☐Self ☐Friend ☐Website/Search ☐TV Ad ☐Paper Ad

☐Doctor: _____ ☐Attorney: _____

Personal Medical History:

Constitutional: ☐Unexplained Weight Gain/Loss ☐Anorexic/Bulimic ☐Obese
Eyes: _____
ENT: _____

Cardiovascular: ☐Angina (Chest Pain) ☐Bleeding/Clotting Problems
☐Anemia ☐Heart Murmur/Mitral Valve Prolapse ☐Heart Disease
☐High Blood Pressure ☐Pacemaker ☐Vascular Disease

Respiratory: ☐Asthma ☐Bronchitis ☐COPD ☐Sleep Apnea

Gastrointestinal: ☐Gastric Problems ☐Reflux ☐Hiatal Hernia
☐Liver Disease ☐Hepatitis

Genitourinary: ☐Kidney Disease ☐Kidney Stones ☐STD's

Musculoskeletal: ☐Arthritis ☐Gout ☐Orthopedic Implants
Skin: _____

Neurological: ☐Migraines ☐Neurological Disorders ☐Stroke ☐Seizures

Psychiatric: ☐Anxiety ☐Depression ☐Psychiatric Treatment

Endocrine: ☐Diabetes ☐Endocrine Disorder ☐Thyroid Problems
Hematologic/Lymphatic: _____

Allergic/Immunologic: ☐HIV Positive

*Are you currently pregnant? ☐Yes ☐No ☐N/A

Hospitalizations/Surgeries (w/date if possible): _____

_____

_____

_____

Allergies (medications/food/environmental): _____

_____

_____

Latex Allergy: ☐No ☐Yes _____

Problems with Anesthesia: ☐No ☐Yes_____

Family Medical History:

☐Arthritis ☐Gout ☐Asthma ☐Bleeding/Clotting Problems ☐Heart Disease

☐Cancer: _____ ☐Diabetes ☐Endocrine Disorder ☐Kidney Disease

☐High Blood Pressure ☐Migraines ☐ Reactions to Anesthesia ☐Vascular Disease

Social History:

Smoking Status: ☐Current Every Day ☐Some Days ☐Former ☐Never

Type: ☐Cigarettes ☐Cigars ☐Smokeless Packs/Day: _____

Duration: ☐< 12 months ☐1 year ☐2 years ☐5 years ☐> 5 years

Alcohol Use: ☐Current Every Day ☐Some Days ☐Former ☐Never

Type: ☐Beer ☐Liquor ☐Wine Drinks/Wk: _____ ☐Socially/Rarely

History of Current Problem (check all that apply):

Type: ☐Injury: _____/_____/_____ Type: _____

☐Auto Accident: _____/_____/_____ Type: _____

☐Previous Surgery: _____/_____/_____ Type: _____

☐Worker's Compensation _____/_____/_____

☐Medical Condition: _____

☐Other/Unknown: _____

Chief Complaint/Reason for Visit

☐Pain ☐Swelling ☐Numbness ☐Deformity ☐Instability ☐Mass

☐Wound ☐Ulcer ☐Callous ☐Other: _____

Location: ☐Left ☐Right

☐Foot ☐Heel ☐Toe(s) ☐Ankle ☐Leg

Duration: _____ weeks _____ months _____ years

Onset: ☐Sudden ☐Gradual ☐Change in Activity ☐Injury ☐Recurring

Severity: ☐Mild ☐Moderate ☐Severe ☐Extreme

Quality: ☐Aching ☐Burning ☐Cramping ☐Dull ☐Radiating ☐Sharp ☐Stabbing ☐Sore ☐Throbbing

Timing: ☐Constant ☐Intermittent ☐With Activity ☐With Palpation/Pressure

Symptoms: ☐Bruising ☐Drainage ☐Inability to Bear Weight ☐Instability ☐Limp ☐Numbness ☐Swelling ☐Tingling ☐None

Pain Worse With: ☐Activity ☐Squatting ☐Stairs ☐Standing ☐Walk/Running ☐Cold ☐Heat ☐Elevation ☐Shoes ☐Evening ☐Morning ☐Since Surgery

Pain Better With: ☐Rest ☐Cold ☐Heat ☐Elevation ☐Medicine ☐Soaking ☐Stretching ☐Massaging ☐Evening ☐Morning ☐Since Surgery

***Pain* Medications for Current Problem:**

Name:_____Dosage:_____Frequency:_____

_____

_____

_____

Treatments Tried: ☐Boot ☐Brace ☐Cast ☐Splint ☐Orthotics/Inserts ☐Injection ☐Crutches ☐Physical Therapy ☐Previous Surgery

Previous Tests: ☐Bone Scan ☐Cat Scan (CT) ☐MRI ☐Nerve Test (EMG) ☐X-Rays Test Performed At: _____

Still have imaging studies? ☐Yes ☐No

Emergency Room Visit: _____

Date: _____/_____/_____

All Current Medications:

Name:_____Dosage:_____Frequency:_____

_____

_____

_____

_____

_____

_____