WELLINGTON ORTHOPEDIC INSTITUTE

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Sex: ○ M ○ F Dominant Hand: ○ L ○ R Height: _____ Weight: _____

Race: _____

Ethnicity: _____

Preferred Language: _____ Referring Physician's Name: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Work History: Are you currently working? ○ Y ○ N

If yes, what is your occupation: _____ Length of time in current position _____

Work Enviornment: e.g. office, outdoors, boat, plane, hot, cold, wet _____

Previous Occupation _____ Length of time in previous position _____

If you are no longer working, when did you stop? _____

Pediatric Patients Only

Who is accompanying the minor patient? ○ Mother ○ Father Other:_____

CHIEF COMPLAINT

Part of the body / reason for being seen today: ○ R ○ L _____

HISTORY OF PRESENT ILLNESS

Please describe how your problem started:

○ Y ○ N NO INJURY
If so, was the onset: ○ Gradual ○ Sudden
Date of Onset: _____

○ Y ○ N INJURY
If so, was the injury related to: ○ Accident ○ Sport
Date of injury: _____

○ Y ○ N WORK RELATED INJURY
If so, was the injury caused by: ○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive Activity
Date of injury: _____

○ Y ○ N AUTO ACCIDENT
Date of accident: _____

Description of Injury / Accident / Problem: _____

○ Y ○ N Have you ever had a problem like this before?
If yes, explain: _____

○ Y ○ N Were you seen in the ER/Urgent Care for this problem?
If yes, where: _____

○ Y ○ N Were any test scans performed for this problem?

If yes, select all that apply: ○ X-Rays ○ MRI ○ CAT Scan ○ Bone Scan ○ Nerve Test (EMG/NCV)

○ Y ○ N Have you received any treatment for this problem?
If yes, explain: _____

On a scale of 0-10 (10 being the worst), how severe is your pain?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Please describe the pain:

○ Constant ○ Intermittent (Comes & Goes) ○ Wakes you up

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ No Pain

Please note if you experience any of the following:

○ Swelling ○ Bruising ○ Numbness ○ Tingling ○ Weakness ○ Loss of Control of Bowel or Bladder

○ Locking/Catching ○ Giving Way ○ Pain ○ Stiffness ○ Other: _____

Since the problem started, is it:

○ Getting Better ○ Worse ○ Unchanged

What makes your symptoms worse:

○ Standing ○ Walking ○ Lifting ○ Twisting ○ Bending ○ Stairs ○ Exercise ○ Squatting ○ Kneeling

○ Sitting ○ Coughing ○ Sneezing ○ Lying inBed ○ Other: _____

What makes your symptoms better:

○ Rest ○ Elevation ○ Ice ○ Heat ○ Other: _____

PAST MEDICAL HISTORY

Cardiovascular

○ Y ○ N Cardiac disease or heart problem

If yes, please explain: _____

○ Y ○ N Deep vein thrombosis

○ Y ○ N Heart surgery _____

○ Y ○ N Pacemaker or AICD

○ Y ○ N Hypertension

○ Y ○ N Lymphedema

○ Y ○ N Atrial Fibrillation

Other: _____

Dermatologic (skin)

○ Y ○ N Herpes

○ Y ○ N Skin Cancer

Other: _____

Endocrine

○ Y ○ N Diabetes, Type _____

○ Y ○ N Hyperthyroidism

○ Y ○ N Hypothyroidism

Other: _____

Gastrointestinal

○ Y ○ N Gastritis / GI Bleed

○ Y ○ N Ulcer

○ Y ○ N Crohn's Disease

○ Y ○ N Ulcerative Colitis

Other: _____

Genitourinary

○ Y ○ N Dialysis

○ Y ○ N Kidney Stones

○ Y ○ N Renal Insufficiency

Other: _____

HEENT

○ Y ○ N Glaucoma

○ Y ○ N Hearing Loss

Other: _____

Hematologic (blood)

○ Y ○ N Anemia

○ Y ○ N Bleeding Tendencies

○ Y ○ N Blood Clotting Abnormalities

○ Y ○ N Hepatitis, Type _____

Other: _____

Immunologic

○ Y ○ N Cancer, Type _____

○ Y ○ N Chemotherapy

○ Y ○ N Radiation Therapy

○ Y ○ N HIV / AIDS

○ Y ○ N Systemic Lupus

Other: _____

Musculoskeletal

○ Y ○ N Fibromyalgia

○ Y ○ N Gout

○ Y ○ N Osteoarthritis

○ Y ○ N Rheumatois Arthritis

Other: _____

Neurological

○ Y ○ N Seizure Disorder

○ Y ○ N Stroke

○ Y ○ N Alzheimer's

○ Y ○ N Parkinson's Disease

○ Y ○ N Neuropathy

Other: _____

 Patient Name: _____

Psychiatric History

- ○ Y ○ N Alcohol Abuse
- ○ Y ○ N Drug Abuse
- ○ Y ○ N Anxiety Disorder
- ○ Y ○ N Depression

Other: _____

Respiratory

- ○ Y ○ N Asthma
- ○ Y ○ N COPD (Chronic Lung Disease)
- ○ Y ○ N Pulmonary Embolism
- ○ Y ○ N Sleep Apnea

Other: _____

Pediatric Patients Only

Immunizations: ○ Current ○ Not Current ○ Exempt

Are you pregant? ○ Y ○ N

Please list and explain any other conditions here:

_____
_____
_____

PAST HOSPITALIZATIONS & SURGICAL HISTORY

Please list all previous hospitalization, surgeries, and procedures including dates here:

_____
_____
_____
_____

MEDICATIONS

Please list all current medications including dosage here:

_____
_____
_____
_____

ALLERGIES

Please list all known drug allergies here:

_____
_____
_____
_____

SOCIAL HISTORY

○ Y ○ N Do you smoke?
If so, how much? _____
If you quit, how long ago? _____

○ Y ○ N Do you drink alcohol?
If so, how much? ○ Social ○ Moderate ○ Heavy

Relationship Status: ○ Single ○ Married ○ Divorced ○ Widowed

Pediatric Patients Only

Patients 12 years old and under:
What is your grade in school?_____
Who lives in the home? ○ Mother ○ Father ○ Sister(s) ○ Brother(s) ○ Other: _____

FAMILY HISTORY

- ○ Y ○ N Cancer
- ○ Y ○ N Diabetes
- ○ Y ○ N Heart Attack
- ○ Y ○ N Heart Disease (other)
- ○ Y ○ N High Blood Pressure
- ○ Y ○ N Stroke

 Patient Name: _____

REVIEW OF SYSTEMS

Allergies (other than to medications)

○ Y ○ N Seasonal
○ Y ○ N Latex
○ Y ○ N Other: _____

Cardiovascular

○ Y ○ N Ankle Swelling
○ Y ○ N Chest Pain
○ Y ○ N Heart Palpitations
○ Y ○ N Murmur
○ Y ○ N Tightness in chest

Constitutional Symptoms

○ Y ○ N Dizziness
○ Y ○ N Fatigue
○ Y ○ N Fever
○ Y ○ N Weight Loss
○ Y ○ N Loss of Appetite
○ Y ○ N Chills
○ Y ○ N Night Sweats

Ear, Nose, Mouth, Throat

○ Y ○ N Hearing Loss
○ Y ○ N Nose Bleeds
○ Y ○ N Sinus Problems
○ Y ○ N Teeth / Gum Problems
○ Y ○ N Swallowing Problems

Endocrine

○ Y ○ N Cuts take longer to heal
○ Y ○ N Hyperglycemia
○ Y ○ N Hypoglycemia
○ Y ○ N Perimenopause

Eyes

○ Y ○ N Cataracts
○ Y ○ N Vision Problems
○ Y ○ N Glasses / Contacts

Gastrointestinal

○ Y ○ N Abdominal Pain
○ Y ○ N Blood in Stool
○ Y ○ N Heartburn
○ Y ○ N Hemorrhoids
○ Y ○ N Ulcer
○ Y ○ N Nausea
○ Y ○ N Vomiting

Genitourinary

○ Y ○ N Blood in Urine
○ Y ○ N Urinary Difficulties

Hematologic

○ Y ○ N Anemia
○ Y ○ N Bleeding Problems
○ Y ○ N Blood Clotting Problems
○ Y ○ N Bruise Easily

Integumentary

○ Y ○ N Keloids / Hypertrophic Scars
○ Y ○ N Psoriasis
○ Y ○ N Rash
○ Y ○ N Ulcerations

Musculoskeletal

○ Y ○ N Back, Joint, or Muscle Pain
○ Y ○ N Weakness

Neurological

○ Y ○ N Balance Problems / Dizziness
○ Y ○ N Neurological Problems / Symptoms
○ Y ○ N Seizures
○ Y ○ N Syncope
○ Y ○ N Numbness
○ Y ○ N Headaches

Psychiatric

○ Y ○ N Addiction to Alcohol / Drugs
○ Y ○ N Depression
○ Y ○ N Anxiety
○ Y ○ N Psychiatric / Emotional Difficulty
○ Y ○ N Sleep Problems

Respiratory

○ Y ○ N Asthma
○ Y ○ N Emphysema
○ Y ○ N Shortness of Breath
○ Y ○ N Cough
○ Y ○ N Wheezing
○ Y ○ N Sleep Apnea

ACKNOWLEDGEMENT

I certify that to the best of my knowledge that the information, which I have provided, is accurate.

Patient/Parent/Guardian Signature_____ Date: _____