The Centers
for Advanced Orthopaedics

Prince William Orthopaedics, Hand Surgery,
& Sports Medicine Center Division

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NAME _____ Date: _____

Age: _____ Height _____ Weight _____ Sex: _____ Handed: L R

Referring Physician: _____ Primary Care Physician: _____

Main Reason for your visit: Pain Weakness Fracture Other _____

How long have you had the problem: _____ Days _____ Weeks _____ Months _____ Years

Location (Circle the body part and side involved): **RIGHT** **LEFT**

Neck	Shoulder	Arm	Elbow	Wrist	Hand	Finger
Back	Pelvis	Hip	Knee	Ankle	Foot	Toe

How did the problem start?

No Injury: Gradual Onset Sudden Onset

Injury: Date _____ How/where did it happen?

Work-Related: Explain _____

Last date worked _____ Current work restrictions _____

Any old injuries that may relate to your current problem? _____

Since your problem started, is it: Getting Better Getting Worse Unchanged Recurrent

Pain: Scale (circle):

0	1	2	3	4	5	6	7	8	9	10
None	Mild			Moderate				Severe		

Quality		Timing	Makes it Worse		Makes it Better	
o Sharp	o Throbbing	o Constant	o Standing	o Sitting	o Rest	o Ice
o Dull	o Aching	o Comes and Goes	o Walking	o Lifting	o Heat	o Motion
o Stabbing	o Burning	o Wakes from Sleep	o Twisting	o Bending	o Elevation	o Massage
o Cramping	o Stiffness	o With Exercise	o Motion	o Squatting	o Medicine	o Therapy
		o After Activity	o Kneeling	o Stairs		

Other Symptoms		
o Swelling	o Numbness	o Catching
o Loss of motion	o Tingling	o Clicking
o Bruising	o Weakness	o Locking

What Tests have been done	
o X-rays	
o MRI	o Bone Scan
o EMG/NS	o Other _____

What medications have you tried? _____

Other Treatments and therapy? _____

Is there a lawsuit or litigation pending in regard to your injury? Yes No

Past or Present Medical Problems: NONE or Check all that apply

o Diabetes	o Gout	o High Blood Pressure	o Kidney Disease	o Parkinson's	o Pregnant
o Hepatitis	o Arthritis	o Heart Trouble	o Liver Disease	o Seizures	o Other Illnesses:
o Ulcers	o Blood Clots	o Bleeding Disorder	o Lung Disease	o Stroke	_____
o Asthma	o Osteoporosis	o Circulation Problems	o Thyroid Disease	o Cancer	_____

Medications: Medication Dose Medication Dose

NONE or _____ _____

Allergies: To Medications:

_____ Latex Eggs Iodine

NONE or _____ Novocaine Adhesives _____

Surgery: Surgery Date Surgery Date

NONE or _____ _____

Have you ever had an adverse reaction to anesthesia? No Yes, describe _____

Family History: Reaction to Anesthesia, Diabetes, Gout, Musculoskeletal Disease, Osteoarthritis, Rheumatoid Arthritis, High Blood Pressure, Bleeding disorder, Heart Disease

NONE or

Social History:

Smoking Status: Never Current Everyday Smoker Current Some Day Smoker
Please circle Heavy Tobacco Smoker Light Tobacco Smoker
Former Smoker Start Date: _____ End Date: _____

Marital Status: M S D W

Do you use Alcohol? No Occasionally Daily

Do you live: Alone With Family With Friends Assisted Living

Current Job Title or Student _____ Employer or School _____

Employment Status: Full duty Working with Restrictions Off Work Disable Retired

Review of Systems: (Circle all that apply)

Constitutional	Head/Ears/Nose/Throat	Cardiovascular	Musculoskeletal
o Weight Loss or Gain	o Frequent headache	o Chest pain	o Multiple joint pain
o Fatigue	o Hearing loss/ringing	o Irregular heart beat	o Multiple joint swelling
o Fever	o Nose bleeds	o Blood clots	o Muscle weakness
o Chills	o Hoarseness	o Varicose veins	o Deformity
o Night Sweats	o Difficulty swallowing	o Ankle swelling	o Tendonitis
	o Dental infections		o Osteoporosis
Skin	**Respiratory**	**Gastrointestinal**	**Genitourinary**
o Rashes	o Wheezing	o Nausea/vomiting	o Incontinence
o Open wounds or sores	o Shortness of breath	o Heartburn/GERD	o Painful urination
o Drainage	o Difficulty breathing	o Stomach pain	o Blood in urine
o Psoriasis	o Productive cough	o Ulcers	o Discharge
	o Pulmonary embolism	o Blood in stool	
Eyes	**Neurologic**	**Psychiatric**	**Other**
o Loss of vision	o Dizziness	o Claustrophobia	o Tumors/lumps/masses
o Double vision	o Loss of balance	o Depression	o Easy bruising
o Blurred vision	o Loss of sensation	o Drug/alcohol addiction	o Hives
	o Blackouts	o Anxiety	o Poor immune system

Patient Signature _____ Date _____ Physician Signature _____ Date _____