EXCEL ORTHOPAEDIC SPECIALISTS

Today's Date: _____

Last Name: _____ First: _____ MI:____ DOB: _____ Age: _____

Preferred Name (nickname): _____ Dominant hand: right_____ left_____

Primary Care Physician: _____ Height: _____ Weight: _____

I was referred by: _____ Occupation: _____

Reason for today's visit: ☐ Left ☐ Right _____

Date problem began? _____

Date of injury? _____ ☐ work injury ☐ motor vehicle accident

Things that make the problem worse:

Things that make the problem better:

What has been done for your problem?

☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT ☐ Bone Scan ☐ Physical Therapy ☐ Injection(s)

Medications (over the counter)? Name:

Medications (prescribed)? Name:

Other?

PLEASE LIST ALL MEDICATIONS, DOSE & FREQUENCY (including herbs and vitamins) ☐ **NONE**

Medication Name	*Dose*	*Frequency*	*Reason for taking this medication*

PLEASE FILL OUT YOUR COMPLETE MEDICAL HISTORY:

High blood pressure?	Y___ N___	Ulcers? Gastrointestinal?	Y___ N___
Diabetes?	Y___ N___	Cancer?	Y___ N___
Heart disease?	Y___ N___	Other (cholesterol, thyroid)?	Y___ N___
Asthma? COPD?	Y___ N___	Sleep apnea?	Y___ N___
Blood clot? Pulmonary embolus?	Y___ N___	Pregnant?	Y___ N___
Blood disorders (i.e. hepatitis, HIV)?	Y___ N___	please explain:	
Other?	Y___ N___	please explain:	

PLEASE LIST ALL ALLERGIC REACTIONS TO MEDICATION (include latex, adhesive tape, etc.) ☐ **NONE**

PLEASE LIST ALL PAST SURGERIES (i.e. tonsils, appendix, screws, plates, joint replacements, etc.) ☐ **NONE**

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM ➡

Date: _____

Name: _____

DOB: _____

PATIENTS AGE 12 AND OLDER

Tobacco: [ ] never smoked → *Tobacco Control Smartform*
[ ] current smoker How many per day? [ ]5 or less [ ]6-10 [ ]11-20 [ ]21-30 [ ]31 or more *(smoker = pamphlet)*
[ ] former smoker How long has it been? [ ]<1mo [ ]1-3mo [ ]3-6mo [ ]6-12mo [ ]1-5yr [ ]5-10yr [ ]>10yr

Alcohol: [ ] Never [ ] 1 x month [ ] 2-4 x month [ ] 2-3 x week [ ] More than 3 x week → *Audit-C Smartform*

Current Height: _____ Current Weight: _____ → *If red, merge BMI Abnormal + pamphlet*

PATIENTS AGE 65 AND OLDER

Fall Risk:	Have you had a fall in the last 12 months?	[ ] No falls	→ *Fall Risk 1*
		[ ] 1 fall without injury	→ *Fall Risk 2*
		[ ] 1 fall with injury*	→ *Fall Risk 3 + pamphlet*
		[ ] 2 or more falls without injury*	→ *Fall Risk 4 + pamphlet*
		[ ] 2 or more falls with injury*	→ *Fall Risk 5 + pamphlet*
Osteoporosis:	Have you ever had a bone density scan?	[ ] Yes [ ] No	→ *If yes, give to Chanthy*
	Have you been diagnosed with Osteoporosis?	[ ] Yes [ ] No	→ *If yes, Osteoporosis YES*
Pneumonia:	Have you ever been given a Pneumonia Vaccine in your lifetime?	[ ] Yes	→ *Other provider / Administered / Date*
	If so, please provide the date: _____	[ ] No	→ *Source unspec / Not admin / Today's date*

REVIEW OF SYSTEMS

Please check off every item that currently applies to you

[ ] Fever
[ ] Chills
[ ] Headache
[ ] Weight loss
[ ] Hearing loss
[ ] Nose bleeds
[ ] Night cramps
[ ] Vision changes
[ ] Shortness of breath
[ ] Cough
[ ] Chest pain
[ ] Palpitations
[ ] Heartburn
[ ] Asthma
[ ] Abdominal pain
[ ] Rash/hives
[ ] Memory loss
[ ] Seizures
[ ] Recurrent UTI
[ ] Bloody urine (hematuria)
[ ] Depression
[ ] Numbness
[ ] Tingling
[ ] History of DVT/blood clot
[ ] Stroke/TIA
[ ] Sleep apnea

[ ] *NONE OF THE ABOVE*