ADVANCED ORTHOPEDICS

Orthopedic Surgery New Patient

Patient Name: _____ **DOB:** _____

Reason for visit: _____

Check all that apply

Location: left right bilateral

Quality: aching burning gnawing stabbing throbbing sharp dull

superficial deep occasional frequency constant worsening improving no change

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Severity: no pain mild moderate severe pain level _____/10 Worst pain _____ / 10

Duration: _____ date of onset _____ days _____ weeks _____ months _____ years

continuous since onset? Yes | No

Timing: cannot identify acute chronic abrupt gradual morning

daytime nighttime recurrent rare occasional

intermittent episodes lasting: _____

Context: cannot identify bending lifting twisting sports injury

work injury MVA assault overuse atraumatic

laceration

Alleviating factors: nothing helps sitting standing lying down position change

heat ice rest elevation exercise stretching limited weight bearing

pt/ot chiropractic care ESI OTC medication narcotics NSAIDs

cortisone injection viscosupplement injection orthotics previous surgery brace sling

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Associated Symptoms: weakness numbness tingling swelling redness warmth

ecchymosis catching/locking popping/clicking grinding instability radiation down arm

drainage feve chills weight loss change in bowel/bladder habits

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Previous Surgery pertaining to today's visit: Yes | No

If yes type of surgical procedure(s) with date(s): _____

ADVANCED ORTHOPEDICS

Orthopedic Surgery New Patient

Patient Name: _____ DOB:: _____

Prior Imaging pertaining to today's visit: none no recent studies xray mri ct scan bone scan emg

If yes, what facility and date(s): _____

Previous Injections: none did not help helped a little helped temporarily helped significantly

Previous Physical Therapy: none did not help helped a little helped temporarily helped significantly

Work related: no yes

Working: no regular duty modified duty

Allergies (Please list all medication/drug allergies with the reaction):

Name of Medication:	Reaction:

Current Medication (Please list all the medications you are currently taking):

Name of Medication	Dose	Directions	What is it for?	Who prescribes it?

Preferred Pharmacy: Advanced Rx Other: _____

***Advanced Rx pick up or mail next day available (Shipping and Handling included). ***

Please Provider Your Past Medical Conditions/Diagnosis

Condition/Diagnosis	Details	Treating Physician

Any addition details: _____

ADVANCED ORTHOPEDICS

Orthopedic Surgery New Patient

Patient Name: _____ DOB: _____

Please Provider Your Past Surgical History

Date of Surgery	Type of Surgery	Hospital	Performed By

Hospitalization other than surgery (include dates):_____

_____

Social History

Any tobacco use? ☐ Yes | ☐ No If Yes, Packs per day _____ for _____ years. If No, Year Quit? _____

Any alcohol use? ☐ Yes | ☐ No If Yes, Drinks per day _____ for _____ years.

Any recreational drug use? ☐ Yes | ☐ No If Yes, Drugs Used_____

Family Medical History:

Has your mother ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your father ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Have any of your siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Have any of your children ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your mother's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your mother's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your father's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your father's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Any other family history and relation to you:_____

Patient Signature:_____**Employee's Initials**: _____**Provider's Initials**:_____