

Upper Bucks Orthopaedic Association

Date: _____

Name: _____ DOB: _____ Height: _____ Weight: _____

Referring Physician: _____ Dominant Hand: Right Left (check one)

Please check the reason for **today's appointment**: Include Right (R), Left (L) or Both (B) where applicable

Hip	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Groin	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Pelvis	<input type="checkbox"/>
Thigh	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Shin	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Finger:	_____
Shoulder	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Clavicle	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Upper Arm	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
Elbow	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Forearm	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Toe:	_____
Hand	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Wrist	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Heel	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
Knee	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Calf	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Back	<input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower
Ankle	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Foot	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Neck	<input type="checkbox"/>

Other: _____

Date of Injury/When Symptoms Started: _____ Where injury occurred: _____

Work Related? Yes No

Motor Vehicle Accident? Yes No

Describe, in DETAIL, injury or reason for visit: _____

Family History: Check any of the following diseases that are in your immediate family (mother, father, sister, brother)

NONE CANCER BONE CANCER HEART / CARDIOVASCULAR DISEASE ANESTHESIA COMPLICATIONS RHEUMATOID ARTHRITIS LUNG DISEASE DIABETES

Social History: Check one that applies

Marital status: Married Single Divorced Separated Widowed
Employment: Student Unemployed Employed Retired Disabled
Tobacco History: Never smoked Current Smoker Smoked in the past only
Alcohol History: Never Drinks Currently drinks Drank in past only

Have you had a **Flu shot** [Influenza vaccine] during **THIS** flu season? (Sept.– Feb.) Yes Date: _____ No

Have you had a **pneumonia shot** [pneumococcal vaccine] during **this year**? Yes Date: _____ No

Medications: Please list all medications you take on a daily basis, including over the counter medications (including vitamins and herbal supplements) and birth control pills OR: No Medications Taken

Past Surgical History: Please check all prior surgeries you have had and specify type

<input type="checkbox"/> NO PRIOR SURGERIES	<input type="checkbox"/> Tonsillectomy/adenoidectomy	<input type="checkbox"/> Breast: _____
<input type="checkbox"/> AICD/Pacemaker	<input type="checkbox"/> Other Heart: _____	<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Angioplasty/stent	<input type="checkbox"/> Vascular: _____	<input type="checkbox"/> C-section
<input type="checkbox"/> Hand surgery: _____	<input type="checkbox"/> Shoulder: _____	<input type="checkbox"/> Wisdom teeth
<input type="checkbox"/> Knee surgery: _____	<input type="checkbox"/> Spine: _____	<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Foot: _____	<input type="checkbox"/> Eye: _____	<input type="checkbox"/> Hernia repair
<input type="checkbox"/> Ankle: _____	<input type="checkbox"/> Hip: _____	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Other Surgeries: _____		

Patient Name/DOB: _____

ALLERGIES: Please list all Medication allergies and the reaction to that medication(s) **No Known Allergies**

MEDICATION

REACTION

_____	_____
_____	_____
_____	_____

Other Allergies (foods, environmental, Latex, etc.): _____

Past Medical History: Please check all that apply:

History of MRSA

Diabetes

Bleeding Disorder

Pulmonary Embolism

DVT (blood clot in leg)

Thyroid Condition

HIV/AIDS

Leukemia/Lymphoma

Organ Transplant

Hiatal Hernia/Reflux

Stomach Ulcers

Coronary Artery Disease

Pacemaker

Heart Murmur

Stroke

High Blood Pressure

Asthma

Emphysema/COPD

Irritable Bowel

Pneumonia

Tuberculosis

Peripheral Vascular Disease

Kidney Stones

High Cholesterol

Osteoporosis

Heart Attack

No known Medical Conditions

Hepatitis

Liver Disease

Anxiety

Depression

Glaucoma

Macular Degeneration

Mental Illness: _____

Benign Prostatic Hypertrophy

Rheumatoid Arthritis

Cancer: [Type] _____

Migraine Headaches

Osteopenia

Other: _____

REVIEW OF SYSTEMS: Have you had any of the following in the **last 6 months?** Please answer at **each** category.

Constitutional: none, weight loss, weight gain, fever, fatigue, chills

Eyes: none, vision change, blurred vision, eye pain

Ears/Nose/Throat/Neck: none, sore throat, nose bleeds, cough, dizziness, snoring, vomiting

Cardiovascular: none, chest pain, palpitations, exercise intolerance, light headed when standing

Respiratory: none, wheezing, chest tightness, coughing up blood

Gastrointestinal: none, constipation, frequent diarrhea, vomiting, abdominal pain

Genitourinary: none, urinary incontinence, hematuria (blood in urine) urinary frequency/urgency

Musculoskeletal: none, muscle weakness, stiffness, arthralgias (joint pain), back pain

Dermatologic: none, rash, skin sores, eczema, psoriasis, keloid scars

Neurologic: none, tinnitus (ringing in ear), tremor, memory loss, seizures, spasms neuropathy

Endocrine: none, chills, flushing, increased thirst, hair loss

Hematologic/ Lymphatic: none, abnormal bleeding, easy bruising, swollen glands

Allergy/Immunology: none, runny nose, sinus pressure, itching, hives, frequent sneezing