Gulfcoast Orthopaedic Specialists, LLP

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Date: _____ Referred By: _____

Name _____ Age _____ Height _____ Weight _____

Chief Complaint _____

Injury Date _____ If not injured, date of first symptom _____

Were you injured at work? _____ Auto Accident? _____ Other _____

Are you working _____ If you are not working, are you off due to this particular problem? Y N

How long have you been off work? _____

Have you had any previous evaluations and / or treatments for this problem? Y N

Physician _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Are your symptoms interrupting your sleep? _____

Please rate your pain level between 1 and 10, 1 being mild and 10 being severe

1 2 3 4 5 6 7 8 9 10

Are you using a walking aid due to this problem? Y N If yes, are you using a cane? Y N

Crutches? Y N Walker? Y N Wheelchair? Y N For how long? _____

To what extent does your injury interfere with the following activities?

Activity	A Lot	Some	None
Work	_____	_____	_____
Housework	_____	_____	_____
Walking	_____	_____	_____
Recreation	_____	_____	_____
Sports	_____	_____	_____
Self Care	_____	_____	_____

Who is your Medical Doctor? _____
And / Or Internist? _____
Cardiologist? _____

Past Medical / Surgery History

Type of Surgery / Medical Condition	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History

Heart Disease Y N	High Blood Pressure Y N	Stomach Ulcers Y N	Kidney Disease Y N
Atrial Fibrillation Y N	Urinary Tract Disease Y N	Gastric Ulcers Y N	Renal Dialysis Y N
Lung Disease Y N	Unexplained Weight Loss Y N	Bleeding Ulcer Y N	Blood Clots Y N
Diabetes Y N	Mental Illness Y N	Bleeding Disorders Y N	DVT Y N
Hepatitis Y N	Cancer Y N	MS Y N	HIV Y N

Other _____

Medications **Dose & Frequency**

_____

_____

_____

_____

_____

_____

Allergies _____

Social History

Single Married Years _____ Widowed Years _____ Divorced

Do you smoke? Y N Cigarettes ____ Cigars ____ Pipe _____ Smokeless Tobacco _____

How Much Per Day? _____ Are you a Former Smoker? Y N For how long? _____

Do you drink any: Beer _____ Wine _____ Other Alcohol _____

How Much Per Day? _____ How often _____

If you are retired, what kind of work did you do? _____

How long have you been retired? _____

What are your hobbies? _____

What kind of recreational activities do you participate in? _____

_____

Family History	If Living, Age	If Living, Health	If Deceased, Age at Death	If Deceased, Cause
Father				
Mother				
Brother or Sister				
Husband or Wife				
Son or Daughter				
Grandchildren				