Hamilton Orthopedic Surgery & Sports Medicine

Name:____ __ Date of Birth____________

Ht:______ Wt:______ BP:_______ P:_______ R:_______

Who is your primary care doctor?:________________________Who referred you to us?:____________________

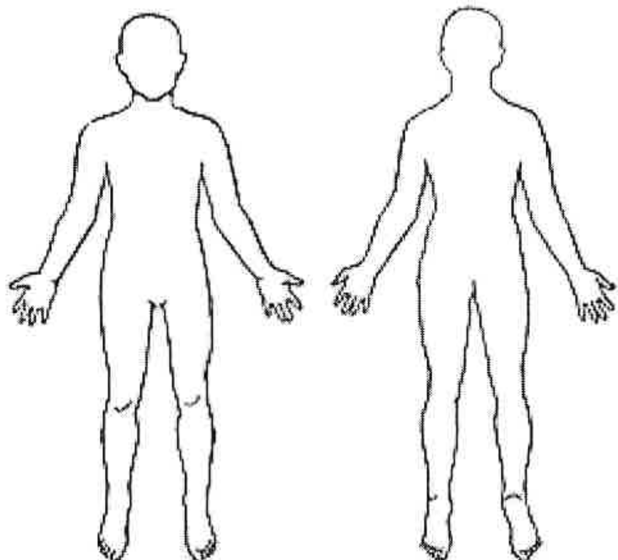
How long have you had the pain?_____________

Was this a result of an injury? (circle one) **Yes or No** If so, what was the date of the injury?:_________

If so, is this a workman's compensation injury (circle one) **Yes or No** or no fault? (circle one) **Yes or No**

Are you currently working? **Yes or No** **Employer:** ________________________ **Job Title:** ____________________

Dominant Hand: **LEFT** or **RIGHT**



Pain Scale

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Have you had any of the following treatments? (Please circle)

NSAID -- Year____________
Was it helpful?

Physical Therapy – Year ____________
Was it helpful?

Chiropractor -- Year____________
Was it helpful?

Injections -- Year____________
Was it helpful?

Acupuncture – Year____________
Was it helpful?

Massage - Year____________
Was it helpful?

Surgery – Year ____________
Was it helpful?

	Do you have pain with...		Are you better with...		Have you had any of the following?
	Lifting		Lifting		X-rays
	Bending		Bending		MRI
	Sitting		Sitting		CT Scan
	Walking		Walking		CT Myelogram
	Laying down		Lying down		Bone Scan
	Activity in general		Activity in general		EMG
	Nothing in particular		Nothing in particular		Stress Echo
	Stairs				

Are you allergic to any medications? (circle one) **Yes or No**

If so, please list:____

Are you allergic to contrast dye of iodine? (circle one) **Yes or No**

Please write in *date* (month & year) and if not done, write "n/a" for the following: Covid vaccine: ____________

Most recent Flu Shot: ________ Pneumonia shot:________ Hepatitis B shots:__________

Female: Physical: _________ Pap Smear/Rectal: ________ Breast Exam: __________ Mammo: _________

Colonoscopy: ______________

Male: Physical: __________ Prostate/Rectal:__________________ Colonoscopy: ____________

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Review Of Systems

Place a check in the box if you have any of these symptoms:

	Fever or Chills		Chest Pain		Blood in Stool
	Weight Loss		Heart Palpations		Change in Bowel Habits
	Double Vision		Shortness of Breath		Urinary Urgency
	Blurred Vison		Skin Issues		Urinary Incontinence
	Changes in hearing		Rashes		Blood in Urine
	Nose Bleeds		Intolerance to Heat		Depression
	Coughing up Blood		Intolerance to Cold		Anxiety

Medical History

Place a check in the box if you have any of the following conditions:

	MRSA infections		COPD		Kidney Stones
	Hepatitis		Asthma		Kidney Disease
	DVT (blood clot)		Heart Attack		Meningitis
	Pulmonary Embolism		Heart Murmur		Epilepsy
	Alcoholism		High Blood Pressure		Headaches
	Arthritis		High Cholesterol		Seizures
	Bleeding Disorders		Rheumatic Fever		Stomach Ulcers
	Cancer		Diabetes		Gastric Reflux
	Stroke		Thyroid Disease		Tuberculosis
	Depression		Anxiety		Bipolar Disorder

Do you have a history of any other medical problems not listed above? (circle one) **Yes or No**

If so, please list:____

Have you had any surgeries? (circle one) **Yes or No**

If so, please list:

Type of Surgery	Date of Surgery	Location of Hospital

Have you been hospitalized for any reason other than the above surgeries? (circle one) **Yes or No**

If so, please list:

Type of Illness	Date of Hospitalization	Location of Hospital

Have you ever required a blood transfusion? (circle one) **Yes or No**

If yes, please explain: ____

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Family History

Please fill in the following table regarding the health of your parents, siblings, and children.

If you cannot answer the question, please write "don't know". If you do not have children/siblings, please write "n/a".

Health Problems DOB

Father:____/________

Mother:____/________

Your Children: How many total?:_______

Health Problems	DOB		Health Problems	DOB
Boys:______________	/_____	Girls:	______________	/_____
______________	/_____		______________	/_____
______________	/_____		______________	/_____

Your Siblings: How many total?: _______

Health Problems	DOB		Health Problems	DOB
Brothers:______________	/_____	Sisters:	______________	/_____
______________	/_____		______________	/_____
______________	/_____		______________	/_____

Social History

Are you married, single, divorced, or widowed? ____________

Do you live alone (circle one) **Yes or No** If no, with whom do you live?____________________

Are you presently employed? (circle one) **Yes or No** If no, why? ____________________

Do you exercise regularly? (circle one) **Yes or No**

Do you need assistive devices to walk? (circle one) **Yes or No** If yes, which one? **walker cane wheelchair**

Do you smoke cigarettes now? (circle one) **Yes or No**

Do you use other tobacco products? (circle one) **Yes or No**

If yes, how many packs a day do you smoke?_____

How many years have you smoked? _____

If you quit, how many packs a day did you smoke? ____

How many years did you smoke?____

Do you drink beer, wine, or liquor?____

If yes, how many do you drink per week?____

Do you use recreational drugs?_____

If yes, please explain:____

Medications

Name of Medication	Strength (example 800mg)	Dosage & Time	Reason for Medication