

## Adult Orthopedic Evaluation

**Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ lbs  
 Right handed \_\_\_\_\_ Left handed \_\_\_\_\_

### **REFERRAL INFORMATION**

Have you seen a physician at Front Range Orthopaedics within the past 3yrs?  Yes  No  
 If yes, for this problem?  Yes  No  
 Another problem?  Yes  No  
 If yes, describe \_\_\_\_\_

Have you seen another physician, chiropractor or podiatrist for this problem?  Yes  No

Who is your **PRIMARY CARE PHYSICIAN**? \_\_\_\_\_

Does your primary care physician know about this problem?  Yes  No

Who referred you to our office? \_\_\_\_\_

Is this a second opinion?  Yes  No

If you went to the Emergency Room, which one did you go to? \_\_\_\_\_

Date you were evaluated \_\_\_\_\_

### **MEDICAL HISTORY: Do you have a history of...**

|                                |       |     |
|--------------------------------|-------|-----|
| Cardiac (Heart) Problems:      | No    | Yes |
| Psychiatric (Depression, ADD): | No    | Yes |
| Breathing Problems:            | No    | Yes |
| Seizures:                      | No    | Yes |
| Eye Problems (glaucoma):       | No    | Yes |
| Endocrine Problems:            | No    | Yes |
| Gastrointestinal Problems:     | No    | Yes |
| Blood /Lymphatic Problems:     | No    | Yes |
| other Musculoskeletal:         | No    | Yes |
| Allergic/Immunologic Problem:  | No    | Yes |
| Skin Problems:                 | No    | Yes |
| Bowel/Bladder Problems:        | No    | Yes |
| Neurological Problems(MS):     | No    | Yes |
| Blood clots / PE/ DVT:         | No    | Yes |
| Sleep Apnea:                   | No    | Yes |
| Other Medical Problems:        | _____ |     |
|                                | _____ |     |
|                                | _____ |     |
|                                | _____ |     |

### **CHIEF COMPLAINT/ PRESENT ILLNESS:**

problem/injury \_\_\_\_\_  
 When did the problem/injury start? \_\_\_\_\_  
 How did the injury happen? \_\_\_\_\_

**Pain severity:**  Mild  Moderate  Severe

**Type of pain:**  Sharp  Dull  Throbbing

**Duration (how long pain lasts):** \_\_\_\_\_

**When is it painful?** \_\_\_\_\_

**What makes it better?** \_\_\_\_\_

**What makes worse?** \_\_\_\_\_

**Do you have any of the following?**  Bruising

Numbness  Tingling and burning  Swelling

Redness

**Does pain wake the patient up at night?**  Yes  No

**Is there morning pain and stiffness?**  Yes  No

**Medicines taken for this problem:**

Tylenol  Ibuprofen

Other: \_\_\_\_\_

**Have you had any of the following diagnostic tests to the area of concern in the last 6-12 months?**

X-rays/ date: \_\_\_\_\_  MRI/ date: \_\_\_\_\_

CT scan/ date: \_\_\_\_\_

Other studies: \_\_\_\_\_ date: \_\_\_\_\_

Location of testing: \_\_\_\_\_

### **FEMALE PATIENTS ONLY:**

Have you started menstruation?  Yes  No

At what age did you start? \_\_\_\_\_

Do you take medication to regulate your period?  Yes  No

Are you pregnant?  Yes  No

# of children \_\_\_\_\_ # of pregnancies \_\_\_\_\_

#of miscarriages \_\_\_\_\_

### **Prior Surgeries & Hospitalizations**

Arthroscopy Yes No Year \_\_\_\_\_

Back Surgery Yes No Year \_\_\_\_\_

Carpal Tunnel Yes No Year \_\_\_\_\_

Fracture Surgery Yes No Year \_\_\_\_\_

Foot/Ankle Yes No Year \_\_\_\_\_

Knee Surgery Yes No Year \_\_\_\_\_

Hip Surgery Yes No Year \_\_\_\_\_

Shoulder Surgery Yes No Year \_\_\_\_\_

Appendectomy Yes No Year \_\_\_\_\_

Tonsillectomy Yes No Year \_\_\_\_\_

Hysterectomy Yes No Year \_\_\_\_\_

Gallbladder Yes No Year \_\_\_\_\_

Other \_\_\_\_\_

### **Reaction to Anesthesia:**

If yes, please describe reaction: \_\_\_\_\_

**Please Complete Both Sides**

**FAMILY HISTORY:** (State which relative, and provide details)

Arthritis \_\_\_\_\_  
Cancer \_\_\_\_\_  
Club Feet \_\_\_\_\_  
Congenital Hip Dislocation \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Epilepsy \_\_\_\_\_  
Heart Attack \_\_\_\_\_  
Heart Problems \_\_\_\_\_  
Hepatitis \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
Nervous Disorders \_\_\_\_\_  
Scoliosis \_\_\_\_\_  
Stroke \_\_\_\_\_  
Tuberculosis \_\_\_\_\_  
Major Anesthesia Problems \_\_\_\_\_

**IMMUNIZATIONS UP-TO-DATE?** Yes No

**CURRENT MEDICATIONS** (include over the counter medications and supplements):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

- No Drug/Contrast Allergy
- No Food Allergy
- No Latex Allergy

Penicillin Yes No  
If Yes, Reaction: \_\_\_\_\_  
Aspirin Yes No  
If Yes, Reaction: \_\_\_\_\_  
Codeine Yes No  
If Yes, Reaction: \_\_\_\_\_  
Sulfa Yes No  
If Yes, Reaction: \_\_\_\_\_  
Iodine Yes No  
If Yes, Reaction: \_\_\_\_\_  
Tape Adhesive Yes No  
If Yes, Reaction: \_\_\_\_\_  
Latex Yes No  
If Yes, Reaction: \_\_\_\_\_  
List allergies and reaction \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**

Single /  Married /  Separated /  Divorced/  Widowed

Education Completed \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Job Duties: \_\_\_\_\_

Lift less than 25lb \_\_\_\_\_ Lift 25-50lbs \_\_\_\_\_  
Lift more than 50lb \_\_\_\_\_  
Sports/Exercise \_\_\_\_\_  
Hobbies \_\_\_\_\_

Cigarettes:  Yes  No  
if yes: # \_\_\_\_\_ Packs Per Day \_\_\_\_\_  
How Many Years? \_\_\_\_\_ Year  
quit \_\_\_\_\_  
Alcohol:  Yes  No  
if yes: # of drinks/beer per week \_\_\_\_\_  
Any history of Drug Abuse: \_\_\_\_\_

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical condition.*

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ /

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ /

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_