LAFAYETTE Orthopaedic Clinic
A UNITY HEALTHCARE PARTNER

Name: _____ Male/Female

Age: _____ Who referred you? _____

Who is your primary care doctor? _____

HISTORY OF PRESENT ILLNESS:

Describe your injury/problem: _____

_____

What side is affected? □R □L When did your injury/problem start? _____

Quality of pain (check): □Sharp □Burning □Dull □Throbbing Night Pain? □YES □NO

Severity (How bad does it hurt?): □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

What makes it worse? _____

What makes it better? _____

What treatments have you tried? _____

PAST MEDICAL HISTORY:

Medications: _____

_____

Allergies: _____

_____

Previous surgeries/hospitalizations: _____

_____

_____

REVIEW OF SYSTEMS: Please check all the medical problems you have:

□ Diabetes	□ Weight Change (+ or -)	□ Blood Clots
□ Stroke	□ Urinary / Bladder Problems	□ Cancer
□ High Blood Pressure	□ Depression	□ Sinus Problems
□ Heart Disease	□ Stomach/Bowel Syndrome	□ Fibromyalgia / Rheumatoid
□ Breathing Problems (Asthma)	□ Gout	□ Pacemaker
□ None Apply		

FAMILY HISTORY: : □ Heart Disease □ Cancer □ Bleeding Problems □ Anesthesia Problems

SOCIAL HISTORY: Alcohol Use: □YES □NO # of drinks /day:_____

Smoker: □Yes □No # of packs/day: _____

Occupation: _____ Employer/School: _____

Help at home: □YES □NO Who: _____

Height: _____ Weight: _____ Dominant Hand: □R □L

X-rays for this injury: □YES □NO Where: _____

Signature: _____ **Date:** _____

Physician Signature_____ **Date** _____