Print Form

Inland Orthopaedic Surgery
& Sports Medicine Clinic

Steven E. Pennington, M.D.

Dr. Pennington's Signature:

Patient Name: _____ Appointment Date: _____

Age: _____ Sex: ☐ M ☐ F Height: _____ Weight: _____ Dominate Hand: ☐ R ☐ L

Primary Care Physician: _____ Clinic Name: _____

Reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other _____

What body part is involved?

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L

How long ago did it start? _____ **Have you had a problem like this before?** ☐ Y ☐ N

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below.

☐ **NO INJURY -** Onset ☐ Gradual or ☐ Sudden

☐ **INJURY -** Accident ☐ Sport ☐ Work ☐ Other

From a: ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach

Date of injury: _____ Employer? _____

What Sport? _____ School? _____

☐ **AUTO ACCIDENT** Date: _____

Additional Notes: _____

On a scale of 0-10 (10 is the worst) **how severe** is your pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On a scale of 0-10 (10 is the worst) what is the **least severe** pain you experience? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes/Goes (intermittent) **Does your pain wake you from your sleep?** ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking/Catching ☐ Giving way ☐ Loss of control of bowel or bladder

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms **worse**? ☐ Standing ☐ Walking ☐ Lifting ☐ Twisting ☐ Bending ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Stairs ☐ Coughing ☐ Sneezing ☐ Lying in Bed

What makes your symptoms **better**? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other: _____

Have you had any of these treatments? Injection: ☐ Y ☐ N Brace: ☐ Y ☐ N Cane/Walker : ☐ Y ☐ N Physical Therapy : ☐ Y ☐ N

Where have you been seen before this? ☐ ER ☐ Dr. Office, who? _____ ☐ PT, where? _____

What tests/scans have you had for this problem? ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test

Where at? _____

Do your other joints have: ☐ Morning stiffness lasting over 30 minutes ☐ Joint pain or swelling ☐ Back pain ☐ Gout ☐ Rheumatoid arthritis ☐ Osteoporosis ☐ Prior fracture (which bone) _____ ☐ None of these

ALLERGIC to any medications? ☐ Y ☐ N **If yes, list & describe reaction**: _____

List medications and doses: If necessary, attach list of medications. **Latex allergy**? ☐ Y ☐ N

CONTINUED ON NEXT PAGE

List <u>All</u> previous Surgeries

Surgery #1 _____ Surgeon _____ City _____ Date _____
Surgery #2 _____ Surgeon _____ City _____ Date _____
Surgery #3 _____ Surgeon _____ City _____ Date _____
Surgery #4 _____ Surgeon _____ City _____ Date _____

Have you had any of these symptoms? If no, mark <u>None.</u>

1. GI ☐ Heartburn, ulcers ☐ Vomiting ☐ Blood in Stool ☐ Hepatitis ☐ Liver Disease ☐ None
2. ENDO ☐ Thyroid Disease ☐ Heat or Cold Intolerance ☐ None
3. CON ☐ Weight Loss ☐ Loss of Appetite ☐ None
4. EYE ☐ Blurred Vision ☐ Double Vision ☐ Vision Loss ☐ None
5. ENT ☐ Hearing Loss ☐ Hoarseness ☐ Trouble Swallowing ☐ None
6. CV ☐ Chest Pain ☐ Palpitations ☐ None
7. RS ☐ Chronic Cough ☐ Shortness of Breath ☐ None
8. GU ☐ Painful Urination ☐ Blood in Urine ☐ Kidney Problems ☐ None
9. SK ☐ Frequent Rashes ☐ Skin ☐ Ulcers ☐ Lumps ☐ Psoriasis ☐ None
10. NEU ☐ Headaches ☐ Dizziness ☐ Seizures ☐ None
11. PSY ☐ Depression ☐ Drug/Alcohol Addiction ☐ Sleep Disorder ☐ C-pap Machine ☐ None
12. HEM ☐ Easy Bleeding ☐ Easy Bruising ☐ Anemia ☐ None

13.Are you HIV Positive: ☐ Y ☐ N

<u>Past Medical History:</u>

Are you Diabetic? ☐ Y ☐ N **If yes, treatment**: ☐ Insulin ☐ Oral ☐ Medications ☐ Diet ☐ None

Are you taking, or have you ever taken blood thinners? ☐ Y ☐ N **If yes, which one?** _____

Have you or a family member ever had a reaction to anesthesia? ☐ Y ☐ N **If yes, explain:** _____

Past Hospitalizations: (not for surgery) _____

Have you ever had: ☐ Heart Attack (year _____) ☐ High Blood Pressure ☐ Blood Clots (year _____) ☐ Stroke
☐ Heart Failure ☐ Ankle Swelling ☐ Kidney Failure ☐ Cancer (location _____)
☐ Stomachache while taking an anti-inflammatory (includes Advil/Aleve)
☐ What anti-inflammatory have you already had a problem with? _____
☐ I do not have any of the above conditions.

<u>Family History</u>:

Have any <u>direct</u> relatives had any of the following disorders? If so, which relative?

☐ Diabetes _____ ☐ High Blood Pressure _____ ☐ Rheumatoid Arthritis _____ ☐ None

Do any direct relatives have the same condition you are being seen for today? ☐ Y ☐ N

<u>Social History:</u>

Do you use tobacco? ☐ Y ☐ N If yes, packs per day _____ Patient informed of Smoking risk? ☐ Y
Alcohol use? ☐ Y ☐ N If yes, how often? ☐ Daily ☐ Other _____ /week
Marital Status: ☐ M ☐ S ☐ D ☐ W **How many people live with you**? _____
Occupation:_____ ☐ Student **Employer**: _____
Current work status? ☐ Regular ☐ Light duty (how long? _____) ☐ Not working due to this problem
☐ Disabled ☐ Retired ☐ Student

Last date you worked your regular job? _____ **Do you plan to be working 6 months from now?** ☐ Y ☐ N

Signature: _____ **Date:** _____

The information on this form is accurate to the best of my knowledge.