



OSUNC
ORTHOPAEDIC SPECIALISTS OF NORTH CAROLINA

Date:	Referring MD:
Name:	Family Physician:
Date of Birth:	Age:
Sex: M F	Race:
	Occupation:
	Employer:

HISTORY (4, 4, 4 elements)

Dominant Hand: RIGHT LEFT BOTH	Work related: YES NO
Date of Injury/Onset:	Need return to work form: YES NO
Body part involved:	Last full day of work:

How injury occurred:
What improves the pain:
What worsens the pain:
Level of pain: 0 1 2 3 4 5 6 7 8 9 10 (0 is none and 10 is as bad as it can get.)

REVIEW OF SYSTEMS (2-9, 10, 10)

Medical Illness (check all that apply)		
<p>General:</p> <p><input type="checkbox"/> Unexplained weight loss</p> <p><input type="checkbox"/> Unexplained weight gain</p> <p><input type="checkbox"/> Fever/Night sweats</p> <p><input type="checkbox"/> Loss of Energy/tired</p>	<p>Endocrine:</p> <p><input type="checkbox"/> Hot/Cold intolerance</p> <p><input type="checkbox"/> High blood sugar</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Frequent urination</p>	<p>Hematology:</p> <p><input type="checkbox"/> Low blood count</p> <p><input type="checkbox"/> Blood clots</p> <p><input type="checkbox"/> Easy bruising</p>
<p>Psychiatric:</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depressed mood/thoughts</p> <p><input type="checkbox"/> Excessive nervousness</p>	<p>Respiratory:</p> <p><input type="checkbox"/> Wheezing/asthma</p> <p><input type="checkbox"/> Productive/chronic cough</p>	<p>Skin:</p> <p><input type="checkbox"/> Unexplained skin changes</p>
<p>GU:</p> <p><input type="checkbox"/> Loss of bladder control</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Increased frequency</p>	<p>GI:</p> <p><input type="checkbox"/> Nausea/vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Change in bowel habits</p>	<p>ENT:</p> <p><input type="checkbox"/> Change in vision</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Voice changes</p> <p><input type="checkbox"/> Frequent colds</p> <p><input type="checkbox"/> Dental problems</p>
<p>Circulatory:</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Inflammation of vessels</p> <p><input type="checkbox"/> Change in hand/foot color or temp.</p>	<p>Neurologic:</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Loss of memory</p>	<p>Cardiac:</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> High blood pressure</p>

Please explain all positive responses below AND any health issues not listed:

HISTORIES: 1, 3, 3

1. PAST MEDICAL HISTORY: Please list all prior and current illnesses and injuries

DRUG ALLERGIES: Please list all

PRIOR SURGERIES: Please list procedure and approximate date

CURRENT MEDICATION:

2. FAMILY HISTORY: Please list any family illnesses

3. SOCIAL HISTORY:

MARITAL STATUS: ___SINGLE ___MARRIED ___SEPARATED ___DIVORCED ___WIDOWED

LIVING ARRANGEMENTS: ___Independent or with Spouse ___With Family ___Assisted Living
___Nursing Home ___Other

ACTIVITY LEVEL: ___Independent (no limits) ___Community activities only ___House bound

DO YOU SMOKE? ___YES ___NO ___PRIOR USE

If yes, smoked _____cigarettes/packs for _____years

DO YOU CONSUME ALCOHOL? ___YES ___NO ___PRIOR USE If yes amount: _____

Any other comments on your general health:

Patient signature and date

Email (optional): _____