## Your Medications

PLEASE LIST ALL THE CURRENT MEDICATIONS YOU ARE TAKING:

## Allergies

PLEASE LIST ALL THE CURRENT ALLERGIES YOU HAVE:

## Current Medical Conditions:

PLEASE LIST ALL THE CURRENT MEDICAL CONDITIONS YOU HAVE:

## Patient Demographics

**RACE:**

| | | | | | |
|---|---|---|---|---|---|
| ○ | American Indian or Alaskan Native | ○ | Asian | ○ | Black or African American |
| ○ | Native Hawaiian or Other Pacific Islander | ○ | White | | |
| | Other: | | | | |

**ETHNICITY:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ○ | Hispanic | ○ | Not Hispanic | ○ | Decline to answer | ○ | Unknown |
| | Other: | | | | | | |

**PREFERRED LANGUAGE:**

| | | | | |
|---|---|---|---|---|
| ○ | English | ○ | Spanish | |
| | Other: | | | |

## Patient Signature:

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## Review Of Systems - Select all problems you have had in the last month?

| CONSTITUTIONAL SYMPTOMS | ○ No To All | |
|---|---|---|
| | Yes | No |
| Fever | ○ | ○ |
| Chills | ○ | ○ |
| Headache | ○ | ○ |

| EYES | ○ No To All | |
|---|---|---|
| | Yes | No |
| Blurred Vision | ○ | ○ |
| Double Vision | ○ | ○ |
| Pain | ○ | ○ |
| Glasses | ○ | ○ |

| NEUROLOGICAL | ○ No To All | |
|---|---|---|
| | Yes | No |
| Tremors | ○ | ○ |
| Dizzy spells | ○ | ○ |
| Numbness/Tingling | ○ | ○ |
| Stroke | ○ | ○ |
| Parkinson's | ○ | ○ |
| Seizures | ○ | ○ |
| Difficulty Standing | ○ | ○ |
| Difficulty Walking | ○ | ○ |
| Difficulty with balance | ○ | ○ |
| Weakness | ○ | ○ |

| ENDOCRINE | ○ No To All | |
|---|---|---|
| | Yes | No |
| Excessive thirst | ○ | ○ |
| Too hot/cold | ○ | ○ |
| Tired/sluggish | ○ | ○ |
| Thyroids | ○ | ○ |
| Diabetes | ○ | ○ |

| GASTROINTESTINAL | ○ No To All | |
|---|---|---|
| | Yes | No |
| Abdominal Pain | ○ | ○ |
| Nausea/Vomiting | ○ | ○ |
| Rectal Bleeding | ○ | ○ |
| Loss of bowel control | ○ | ○ |
| Ulcers | ○ | ○ |

| CARDIOVASCULAR | ○ No To All | |
|---|---|---|
| | Yes | No |
| Myocardial infarction | ○ | ○ |
| Leg swelling or edema | ○ | ○ |
| High blood pressure | ○ | ○ |

| INTEGUMENTARY | ○ No To All | |
|---|---|---|
| | Yes | No |
| Skin rash | ○ | ○ |
| Boils | ○ | ○ |
| Persistent itch | ○ | ○ |

| MUSCULOSKELETAL | ○ No To All | |
|---|---|---|
| | Yes | No |
| Osteoarthritis | ○ | ○ |
| Rheumatoid arthritis | ○ | ○ |
| Neck pain | ○ | ○ |
| Back pain | ○ | ○ |
| Use of cane or crutch | ○ | ○ |

| EAR/NOSE/THROAT/MOUTH | ○ No To All | |
|---|---|---|
| | Yes | No |
| Ear infection | ○ | ○ |
| Sore throat | ○ | ○ |
| Sinus problems | ○ | ○ |
| Dental problems | ○ | ○ |

| GENITOURINARY | ○ No To All | |
|---|---|---|
| | Yes | No |
| Difficulty urinating | ○ | ○ |
| Blood in urine | ○ | ○ |
| Urinary frequency | ○ | ○ |
| Loss of bladder control | ○ | ○ |

| RESPIRATORY | ○ No To All | |
|---|---|---|
| | Yes | No |
| Asthma attack | ○ | ○ |
| Frequent cough | ○ | ○ |
| Shortness of breath with activity | ○ | ○ |

| HEMATOLOGIC/LYMPHATIC | ○ No To All | |
|---|---|---|
| | Yes | No |
| Swollen glands | ○ | ○ |
| Blood clots | ○ | ○ |
| Bleeding problems | ○ | ○ |
| Leg swelling or edema | ○ | ○ |

| PSYCHOLOGICAL | ○ No To All | |
|---|---|---|
| | Yes | No |
| History of depression | ○ | ○ |
| History of anxiety | ○ | ○ |
| History of bipolar | ○ | ○ |
| History of schizophrenia | ○ | ○ |

○ Other - Print Below

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## Surgical History

| HAVE YOU HAD ANY SURGERIES? | ○ Yes | ○ No | If yes, please indicate below |
|---|---|---|---|

| | Left | Right | | Left | Right | | |
|---|---|---|---|---|---|---|---|
| Arthroscopy Knee | ○ | ○ | Rotator Cuff Repair | ○ | ○ | Appendectomy | ○ |
| Arthroscopy Shoulder | ○ | ○ | Carpal Tunnel Release | ○ | ○ | Hysterectomy | ○ |
| Total Knee Replacement | ○ | ○ | Lumpectomy | ○ | ○ | Malignancy/Cancer | ○ |
| Total Hip Replacement | ○ | ○ | Mastectomy | ○ | ○ | Cataracts | ○ |
| Total Shoulder Replacement | ○ | ○ | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Back Surgery: Level : | ○ | Hernia | ○ | Gall Bladder | ○ |
| Neck Surgery: Level : | ○ | Bowel Surgery | ○ | Renal | ○ |

○ Other - Print:

| ANY ADVERSE REACTIONS TO ANESTHESIA? | ○ Yes | ○ No | If Yes, please describe below |
|---|---|---|---|

## Family History

| ANY HISTORY OF FAMILY MEDICAL CONDITIONS? | ○ Yes | ○ No | ○ Unknown |
|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| ○ | Arthritis | ○ | Phlebitis | ○ | Stroke |
| ○ | Anxiety/Depression | ○ | Cancer, Type: | | |
| ○ | Diabetes | ○ | Heart Disease | | |
| ○ | Hereditary Defects | ○ | Hypo Thyroid | | |
| ○ | Gout | ○ | Liver Disease | | |

○ Other - Print below

## Social History

| DO YOU SMOKE TOBACCO? | ○ Yes | ○ No |
|---|---|---|

| | | | | |
|---|---|---|---|---|
| If yes, how many packs per day? | ○ Less than one pack | ○ One pack | ○ Two packs | ○ Three + packs |
| How many years have you smoked? | ○ 1-5 years | ○ 6-10 years | ○ 11-20 years | ○ 20 + years |

| | | | |
|---|---|---|---|
| If you previously smoked, how long has it been since you quit smoking? | | | years |
| If yes, how many years did you smoke before you quit? | | | years |

| DO YOU DRINK ALCOHOL? | ○ Yes | ○ No |
|---|---|---|

| | | | | |
|---|---|---|---|---|
| If yes, how, frequently do you drink? | ○ 1x week | ○ 2x week | ○ 3x week | ○ More than 3x week |

| | | | |
|---|---|---|---|
| DO YOU LIVE ALONE? | ○ Yes | ○ No | |
| Who do you live with | ○ Spouse | ○ Family | ○ Friend |

| ARE THERE STAIRS IN YOUR HOME? | ○ Yes | ○ No |
|---|---|---|

| DO YOU HAVE A HISTORY OF RECREATIONAL DRUG USE? | ○ Yes | ○ No | ○ Prior use |
|---|---|---|---|

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| HOW DID THE INJURY OCCUR? |
|---|
| |

| ON THE SCALE BELOW, MARK THE SEVERITY OF THE PAIN, 10 BEING THE HIGHEST | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | | | | | | | Moderate | | | | | | Severe | | | | | |
| ○ | 0 | ○ | 1 | ○ | 2 | ○ | 3 | ○ | 4 | ○ | 5 | ○ | 6 | ○ | 7 | ○ | 8 | ○ | 9 | ○ | 10 |

| HOW CAN THE CURRENT PROBLEM BE CHARACTERIZED? | | | | | |
|---|---|---|---|---|---|
| ○ | Intermittent | ○ | Constant | ○ | Burning |
| ○ | Dull | ○ | Sharp | ○ | Stabbing |
| ○ | Throbbing | ○ | Aching | ○ | Cramping |
| ○ | Pressure | ○ | Radiating | ○ | Electrical |

| ARE THE SYMPTOMS WORSE DURING THE DAY OR NIGHT? | | | | | |
|---|---|---|---|---|---|
| ○ | No difference | ○ | Day | ○ | Night |

| WHAT ADDITIONAL SYMPTOMS ARE PRESENT? | | | | | | | |
|---|---|---|---|---|---|---|---|
| ○ | Chills | ○ | Fever | ○ | Numbness | ○ | Loss of bowel control |
| ○ | Stiffness | ○ | Tingling | ○ | Weakness | ○ | Loss of bladder control |
| ○ | Swelling | ○ | Instability | ○ | Fatigue | ○ | Limit of motion |
| ○ | Headaches | ○ | Radiation of pain | ○ | Sleep disturbance | ○ | Loss of feeling |
| | Other: | | | | | | |

| SINCE THE ONSET, WHAT IS THE STATUS OF YOUR PROBLEM? | | | | | |
|---|---|---|---|---|---|
| ○ | Improved | ○ | Worsening | ○ | No Change |

| SYMPTOMS FEEL WORSE WITH? | | | | | | | |
|---|---|---|---|---|---|---|---|
| ○ | Rest | ○ | Activity | ○ | Sitting | ○ | Lifting |
| ○ | Ice/Cold | ○ | Heat | ○ | Movement | | |
| | Other: | | | | | | |

| SYMPTOMS IMPROVE WITH? | | | | | |
|---|---|---|---|---|---|
| ○ | Rest | ○ | Activity | ○ | Medication |
| ○ | Ice/Cold | ○ | Heat | ○ | Movement |
| | Other: | | | | |

| PRIOR INJURIES OF A SIMILAR NATURE? | | ○ | No | ○ | Yes |
|---|---|---|---|---|---|
| | Explain: | | | | |
| | | | | | |

| PRIOR SURGEY FOR THIS PROBLEM? | | ○ | No | ○ | Yes |
|---|---|---|---|---|---|
| | Name of surgeon: | | | | |
| | Date of surgery: | | | | |

| PRIOR TREATMENT/TESTING? | | ○ | No | ○ | Yes | | |
|---|---|---|---|---|---|---|---|
| ○ | Chiropractor | ○ | EMG | ○ | ER | ○ | Epidural Blocks |
| ○ | Injections | ○ | MRI | ○ | Muscle relaxants | ○ | NSAID’s |
| ○ | Pain Meds | ○ | PT | ○ | Surgery | ○ | X-Rays |
| ○ | CT Scan | ○ | Other MD: | | | | |

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# UNION COUNTY ORTHOPAEDIC GROUP (UCOG)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD

**Today's date**

**Last name**

**First name** **MI**

**Your height and weight**

ft inches lbs

**Your age**

**Date of birth**

day mth yr

## HISTORY OF PRESENT ILLNESS.

| UPPER BODY | R | L | LOWER BODY | R | L | NECK/BACK | | |
|---|---|---|---|---|---|---|---|---|
| Arm | ○ | ○ | Lower Leg | ○ | ○ | Neck | | ○ |
| Shoulder | ○ | ○ | Pelvis | ○ | ○ | Upper Back | | ○ |
| Elbow | ○ | ○ | Hip | ○ | ○ | Mid Back | | ○ |
| Forearm | ○ | ○ | Thigh | ○ | ○ | Low Back | | ○ |
| Wrist | ○ | ○ | Knee | ○ | ○ | Buttocks | | ○ |
| Hand | ○ | ○ | Calf | ○ | ○ | | | |
| Thumb | ○ | ○ | Ankle | ○ | ○ | | | |
| Index | ○ | ○ | Foot | ○ | ○ | | | |
| Middle | ○ | ○ | Great Toe | ○ | ○ | | | |
| Ring | ○ | ○ | 2nd Digit | ○ | ○ | | | |
| Pinky | ○ | ○ | 3rd Digit | ○ | ○ | | | |
| | | | 4th Digit | ○ | ○ | | | |
| | | | 5th Digit | ○ | ○ | | | |

| HOW LONG HAVE THE SYMPTOMS BEEN PRESENT? | | | | |
|---|---|---|---|---|
| | DAYS | WEEKS | MONTHS | YEARS |
| 1 | ○ | ○ | ○ | ○ |
| 2 | ○ | ○ | ○ | ○ |
| 3 | ○ | ○ | ○ | ○ |
| 4 | ○ | ○ | ○ | ○ |
| 5 | ○ | | ○ | ○ |
| 6 | ○ | | ○ | ○ |
| 7 | | | ○ | ○ |
| 8 | | | ○ | ○ |
| 9 | | | ○ | ○ |
| 10 | | | ○ | ○ |
| 11 | | | ○ | ○ |

| ONSET OF SYMPTOMS? | | | | | |
|---|---|---|---|---|---|
| ○ | Unknown | ○ | Gradually | ○ | Suddenly, without injury |
| ○ | After an Injury | Date of Injury : | | | |

| WORK OR MOTOR VEHICLE? | | | |
|---|---|---|---|
| ○ | Motor Vehicle | ○ | Work |

| MOTOR VEHICLE ACCIDENT *Only answer if injury was the result of a motor vehicle accident* | | | | |
|---|---|---|---|---|
| Name of the attorney, if applicable : | | | | |
| Where were you when the accident happened? | ○ | Driver | ○ | Pedestrian |
| | ○ | Front seat passenger | ○ | Back seat passenger |
| Were you wearing a seat belt? | ○ | No | ○ | Yes |

| WORK INJURY *Only answer if injury was the result of a work related injury* |
|---|
| Name of the employer : |
| Date reported : |
| Not reported to employer ○ |

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