River Region Orthopedics

William S. Johnson, MD **Linda Thompson, MD**

Name ______________________________ **Age** ______ **Sex** ______ **Date** _________

What is your main complaint today? ____

When did this condition begin? ____

Where were you when this condition began? ____

How did this condition begin? ____

____

If an accident, do you have an attorney? ______________

Are you in pain? ________ Describe the pain: Sharp _____ Dull _____ Burning _____ Ache _____

Rate your pain on a scale 1 to 10 (10 being the worst) _______

Have you been treated for this problem by: ER ______ Another Doctor ______ When______________

Were x-ray's taken? ________________ Did you bring them? __________________

Are you taking any medication for this problem? _______________________________________

Who referred you to our office ______________ Who is your family doctor ______________________

Have you ever suffered any trauma (fractures, dislocations, or back problems)? ______ If yes, explain:

____

Weight _____ **Height** _____ **Pulse** _____ **Resp.** _____ **Right hand** ____ **Left hand** ____

Dictated:
Diagnosis:
Reviewed:
Xrays:
Injection:
Brace/cast:
FU visit:

Medical history:

	Yes	No		Yes	No
1. High Blood Pressure	____	____	10. Heart Disease	____	____
2. Seizures	____	____	11. Lung Disease	____	____
3. Diabetes	____	____	12. Kidney Disease	____	____
4. Thyroid Disease	____	____	13. Cancer	____	____
5. GYN	____	____	14. Spine Disease	____	____
6. Hepatitis, liver disease	____	____	15. Arthritis	____	____
7. Gastrointestinal	____	____	16. TB	____	____
8. Stomach Ulcers	____	____	17. Blood Transfusions	____	____
9. HIV	____	____	18. Other	____	____

Explain: ____

List past surgeries: ____

Female Patients: Are you pregnant? ____________

Family Medical History: Cancer Heart Disease Diabetes Hypertension Arthritis

Social History:

Occupation ________________________ Marital Status: M S D W

Do you use: Tobacco? ______ How much? ________ Alcohol? ______ How much? _______

Education? ______________________ Hobbies? ____________________________

Allergies? ____

Present Medications ____

____

____

____

Herbal Supplements ____

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System Review: Check if you have had any of the following symptoms or findings:

General	___Skin Rash ___Lethargy/weakness ___Loss of interest in eating ___Always hungry ___Tend to be hot or cold ___Chills/night sweats ___Sleeping difficulties ___No problems	GI	___Heartburn or indigestion ___Belching or nausea ___Jaundice ___Difficulty swallowing ___Stomach pain ___Vomiting blood ___Constipation ___Recent change in bowel habits ___Loose bowels/diarrhea ___Black or bloody stools ___Pain in rectum ___Hemorrhoids ___Amoeba/parasites ___No problems
Head	___Frequent headaches ___Dizzy spells ___Fainting spells/unconsciousness ___No problems		
Eyes	___Wear glasses ___Eyesight worsening ___Double vision ___Eye pain or itching ___No problems	GU	___Frequent night or day voiding ___Burning on urination ___Pus or blood in urine ___Difficulty starting urine ___Dribbling with coughing/sneezing ___Other kidney disease ___Sex difficulties ___No problems
Ears	___Deafness ___Earaches or drainage ___Noise in ears ___No problems		
Nose	___Congestion/sneezing ___Sinus trouble/hay fever ___Nose bleeds ___No problems	Nervous	___Convulsions/seizures ___Stroke/paralysis ___Difficulty making decisions ___Memory problems ___Cry often/depressed/feel sad ___Worry a lot ___Considered suicide ___No problems
Throat	___Sore throat or tongue ___Hoarse voice ___Dental problems ___Goiter/thyroid trouble ___Neck pains or lumps ___No problems	Miscellaneous	___Bleed/bruise easily ___Anemia/low blood ___Blood disease ___Englarged glands/nodes ___Aching muscles/joints ___Varicose veins ___Leg cramps/pains ___Leg cramps/pains ___Painful feet ___Cancer ___Prolonged fever ___No problems
Lung and Heart	___Wheezing/coughing spells ___Cough up phlegm ___Shortness of breath ___Emphysema ___Cough up blood ___Exposed to TB ___Heart racing/palpitations ___High blood pressure ___Swollen feet or ankles ___Chest pains ___Heart attack ___Heart murmur ___No problems		

Men	Only	___Weak urine stream ___Prostate trouble ___Lump on testicles	___Impotence ___Change in sex desire ___Burning or discharge ___No problems
Women	Only	___Cesarean Section ___Hysterectomy ___Possibly pregnant	

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