College Park Family Care Center, P.A.

New Patient Orthopedic History

Please complete all questions

Patient Name: _____ **Date of Birth**: _____

Occupation: _____

Chief Orthopedic Complaint: _____

How were you referred to our office: _____

In order to facilitate the efficiency of your appointment, please only include that which you scheduled as your chief complaint.

Complaints of:

____pain at rest ____pain with motion ____limited motion ____difficulty sleeping ____weakness

____swelling ____locking ____numbness ____tingling ____feeling of instability

____sharp ____dull ____ constant pain ____redness ____warmth ____popping ____stiffness

Injury: ____ Yes ____No If Yes, how did injury occur_____

Pain over the last: ____ 1-3 day's ____1 week's ____2-3weeks ____1 month ____6 month's ____12 months

Mechanism of Injury: ____none ____fall ____MVA ____sporting injury ____work injury ____twisting injury

Previous Care: ____Emergency Department ____Urgent Care ____Primary Care Physician ____ OTC Meds

Immobilized in: ____ cast ____splint ____sling ____boot ____none

Gained relief from: ____NSAID's ____Rest ____Tylenol ____Home Exercise Program ____Ice ____Narcotics

Tried and failed: ____Physical Therapy ____Cortisone injection ____Euflexxa series ____NSAID's ____Home Exercise Program

Patient has had: ____ Previous Surgery ____Formal Physical Therapy ____Legal Representation ____ Previous Ortho Consult _____Previous X-ray/MRI If yes, where_____

Current Medication and dosage:

_____

_____

Continued on Reverse>>

Medical History:_____
_____
_____
_____

Medication Allergies:_____
_____
_____

Previous Surgical Procedures and Dates:_____
_____
_____

Past Hospitalization:_____
_____
_____

Family History:

Mother: ____ Alive ____Deceased Father: _____Alive _____Deceased

Social History:

Do you smoke? ____Yes ____ No ____# of packs per day ____how many years

Do you exercise? ____Yes ____No