AZALEA ORTHOPEDICS

PATIENT MEDICAL PROFILE

Visit Information

Patient Name: ____ DOB: ___________ Age: _______

Reason for Visit: ____ Referring Physician: ______________

Primary Care Physician: _____________________________________ Height: __________ Weight: ______

Type of Pain: ☐Ache ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click / Pop Date of Injury: ___/___/___

Severity: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable Are you left of right handed? ☐ Left ☐ Right ☐ Both

Location of Pain: Back _________% Legs _________% OR Neck _________% Arms _________%

Duration of Pain: _______ ☐ Dull then Sharp ☐ Always There ☐ Very Sharp, the Leaves ☐ Constant ☐ Intermittent

Pain Aggravated By:

☐ Standing ☐ Sleeping
☐ Walking ☐ Lying
☐ Stairs ☐ Sitting
☐ Driving
☐ Working

Treatments Attempted:

☐ Pain Medications ☐ Anti – Inflammatory
☐ Rest ☐ Wheelchair
☐ Physical Therapy ☐ Surgery
☐ Ice ☐ NONE
☐ Oral Steroids ☐ Epidural Steroid Injections

History of Present Illness

Was this a work related accident? Yes No
Was this an auto accident? Yes No
Recreational or school athletic injury? Yes No
Accident in your home? Yes No
Accident other than above? Yes No
Explain: ______________________________
Are you currently working? Yes No
If yes, are you working: Full Duty or Limited Duty
List any other doctors you have seen for this problem:
____
____
List any previous tests or procedures for this problem:
____
____

Explain Injury or Illness:
____
____
____
Describe the symptoms you are having:
____
____
____
Does the problem interfere with your normal functions?
Yes No If yes, explain: __________________
____
Do you have a history of MRSA?
Yes No If yes, explain: __________________
____

Current Health

Please list any health problems that you are currently diagnosed with:

☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ DVT (Blood Clots) ☐ Pulmonary Embolism
☐ Liver Disease / Jaundice ☐ Lung Disease ☐ Cancer ☐ Stomach Ulcers ☐ Seizures
☐ Osteoarthritis / Gout ☐ Asthma ☐ Thyroid Problems ☐ Kidney Disease ☐ Rheumatoid Arthritis
☐ Chronic Headache ☐ Depression ☐ Anxiety ☐ Urinary or Bowel Incontinence
☐ Infections: Please Explain: ____
☐ Other Illness: Please Explain: ____

Females Only: Date of Last Menstrual Period: ___/___/___ Currently Pregnant? ☐ Yes ☐ No ☐ Possibly

Check Immunizations: ☐ Flu – Approx. Date: __/__/__ ☐ Tetanus – Approx. Date: __/__/__ ☐ Pneumonia – Approx. Date: __/__/__
☐ Colon Screening – Approx. Date: __/__/__ ☐ Mammogram – Approx. Date: __/__/__ ☐ Bone Density – Approx. Date: __/__/__

Allergies

Please check all known Drug Allergies:

☐ None known ☐ Iodine ☐ Diagnostic Dyes ☐ Morphine
☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Tramadol
☐ Sulfa Drugs ☐ Hydrocodone ☐ Latex ☐ Cephalosporins
☐ Other:____