Wenatchee Valley Medical Center Orthopedics

Patient Information

Place label here.

Age:______ Occupation:________________________________
Hand Domination: Right______ Left______
Please indicate current problems:______________________________
____
Date of Injury:________________ L&I#______________________
Referred by: Self______ or Dr. ___________________________
Is this condition work related? Yes No
Have you ever received treatment for this condition? Yes No
If so, what prior treatments have been instituted?
____
(For example: medications, x-rays, injections, surgery, physical therapy and/or chiropractic.)

To be filled out by nurse

Wt.__________ BP__________________
Temp________ P_______ RR________
____
____
____

Please rate your pain on a scale of 1 to 10 (10 being the most painful):

At rest:	0	1	2	3	4	5	6	7	8	9	10
At its worst::	0	1	2	3	4	5	6	7	8	9	10

What makes your pain better?______________________________________
What makes your pain worse?______________________________________

Current symptoms for this problem: Swelling_____ Stiffness_____ Giving Way_____ Weakness_____ Pain at night_____
Numbness_____ Warmth_____ Tingling_____ Popping_____ Burning_____ Locking_____ Instability_____ Other_____

Do you use: Cane_____ Walker_____ Wheelchair_____ Braces_____

PAST MEDICAL HISTORY

Have you had any of these medical problems?

Asthma	Yes	No
Blood Clots	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Kidney Disease	Yes	No
Pneumonia	Yes	No
Rheumatoid Arthritis	Yes	No
Seizures	Yes	No
Stroke	Yes	No
Ulcer	Yes	No
Are You Pregnant?	Yes	No

FAMILY HISTORY

Has anyone in your family ever had any of these conditions?

Arthritis	Yes	No
Bleeding Disorder	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
Kidney Problems	Yes	No
Rheumatoid Arthritis	Yes	No
Stroke	Yes	No

Other:______________________________

AS OF THIS DATE
ALLERGIES TO MEDICATIONS:

1.______________________________
2.______________________________

SOCIAL HISTORY

Do You Use?

Tobacco	Yes	No
If yes, how many packs per day?	__________	
Years of smoking?	__________	
Alcohol	Yes	No
If yes, how many drinks per day?	__________	
Do you have, or have you had a problem with chemical dependency?	Yes	No

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

1.______________________________
2.______________________________
3.______________________________
4.______________________________

PREVIOUS SURGERIES (list):____

REVIEW OF SYSTEMS: Do you have any of these symptoms? Please circle either YES or NO for each condition.

Constitutional		
Fever/Chills	Yes	No
Weight Loss	Yes	No
Weight Gain	Yes	No
Cardiovascular		
Chest Pain	Yes	No
Irregular Heart Beat	Yes	No
Poor Circulation	Yes	No
GU		
Bloody Urine	Yes	No
Pain on Urinating	Yes	No
Unable to Urinate	Yes	No
Neurological		
Paralysis	Yes	No
Frequent Headaches	Yes	No
Blood		
Bleeding Problems	Yes	No
Previous Blood Transfusions	Yes	No

Eyes		
Decreased Vision	Yes	No
Cataracts	Yes	No
Lungs		
Shortness of breath	Yes	No
Wheezing	Yes	No
Persistent Cough	Yes	No
Musculoskeletal		
Joint Swelling	Yes	No
Muscles Aches	Yes	No
Joint Pain	Yes	No
Psychiatric		
Depression/Anxiety/Panic	Yes	No
Bipolar Disease	Yes	No
Allergic		
Allergies to Foods	Yes	No
Allergies to Latex	Yes	No

Ear, Nose, and Throat		
Loss of Hearing	Yes	No
Sinus Problems	Yes	No
Gastrointestinal		
Stomach Pain	Yes	No
Diarrhea	Yes	No
Persistent Vomiting	Yes	No
Heartburn	Yes	No
Skin		
Rash	Yes	No
Dryness of Skin	Yes	No
Endocrine		
Thyroid Problems	Yes	No
Diabetes	Yes	No
Other:		

Are you currently being treated for any of these conditions? Yes No