CORE ORTHOPEDICS & SPORTS MEDICINE

PATIENT ASSESSMENT

PLEASE PRINT USING BLACK OR BLUE PEN ONLY.

Patient's Legal Name: (Last)	(First)	(M.I.)

Patient's Age:________Years Date of Birth: / / Height: (Ft) (In) Weight:

This form is being completed by: ☐ Patient ☐ Spouse ☐ Parent ☐ Guardian ☐ Other:

Who is your Medical Doctor or Primary Care Physician?	Who referred you to Core?
Name:__________________________	☐ Friend ☐ E.R./Hosp. ☐ Yellow Pages
Address:________________________	☐ Doctor____________________ ☐ Other
City:__________________ State Zip	Occupation:______________________________
Phone: ( ) _____________________	How long have you been doing this work?__________________

Pharmacy Name:_____________________________Pharmacy Phone: ( ) ____________________

HISTORY OF PRESENT ILLNESS (HPI)

Where is your pain located? ____ ☐ RIGHT ☐ LEFT
(Example: wrist, ankle, low back)

Which is your dominant hand? ☐ RIGHT ☐ LEFT

Approximate **date** of the onset of the present problem: ______________________________

How did **this** problem occur? ____

Any previous problems to **this** area? ☐ No ☐ Yes If yes, describe: ______________________

1. Who have you seen for **this** problem? ☐ Not Previously Seen ☐ Family Physician
   ☐ Emergency Room ____________________ ☐ Other ____________________
   (Hospital)
2. Check off all past tests or treatments for **this** problem: ☐ X-ray ☐ Splint ☐ Medication ☐ Physical Therapy
   ☐ MRI ☐ Surgery ☐ Other ____________________
3. Intensity of pain (circle one): **None** 1 2 3 4 5 6 7 8 9 10 **Severe**
4. My pain is: ☐ Intermittent ☐ Constant
5. When do symptoms occur? ____
   (Example: after exercise, after long walks, after sitting for long periods of time, etc.)
6. Type of pain: ☐ Burning ☐ Aching ☐ Stabbing ☐ Sharp
   ☐ Shooting ☐ Deep ☐ Other ____________________
7. Does the pain radiate? ☐ No ☐ Yes To where? ______________________________

   If you have neck pain, what percentage is neck pain ____%, and what percentage is radiating pain to arm ____%
   (Example: 80% neck pain, 20% arm pain)

   If you have back pain, what percentage is back pain ____%, and what percentage is radiating pain to leg ____%
   (Example: 50% back pain, 50% leg pain)

MEDICAL HISTORY

	NO	YES		NO	YES		NO	YES
Anemia	☐	☐	Heart attack	☐	☐	Shingles	☐	☐
Alzheimers	☐	☐	Heart palpitations	☐	☐	Steroid Use	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	Stomach ulcers	☐	☐
Bladder control problems	☐	☐	Kidney disease	☐	☐	Stroke/TIA	☐	☐
Bladder infections	☐	☐	Liver disease	☐	☐	Thyroid disease	☐	☐
Bleeding tendency	☐	☐	Lupus erythematosus	☐	☐	Tuberculosis	☐	☐
Blood clots (DVT) *site* ___________	☐	☐	Migraine headache	☐	☐	Varicose veins	☐	☐
Cancer *site* ___________	☐	☐	Osteoarthritis	☐	☐			
Diabetes	☐	☐	Osteoporosis	☐	☐	Anxiety	☐	☐
Diverticulitis	☐	☐	Pneumonia	☐	☐	Depression	☐	☐
Emphysema/COPD	☐	☐	Psoriasis	☐	☐	Hepatitis A, B, or C	☐	☐
Esophageal reflux (GERD)	☐	☐	Rheumatoid arthritis	☐	☐	HIV	☐	☐
Glaucoma	☐	☐	Sciatica	☐	☐	Seizures	☐	☐
Gout	☐	☐						

Any other medical problems not listed?____

PAST SURGICAL / HOSPITALIZATION HISTORY

Year	Hospital/Location	Reason

MEDICATION HISTORY

Please include prescription drugs, vitamins and drugs you buy over the counter.

Medication	Dose/Strength	When do you take it?	Reason you take the medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES - List any allergies you have and what type of allergic reaction you experience.

☐ NO ALLERGIES

1. Allergy:	Reaction:
2. Allergy:	Reaction:
3. Allergy:	Reaction:
4. Latex Allergy: ☐ Yes ☐ No	Reaction:

SOCIAL HISTORY

Do you smoke? ☐ NO ☐ YES Packs/Day____________ Years____________

Do you drink alcohol? ☐ NO ☐ YES Drinks/Day____________ Years____________

Do you take a special diet? ☐ NO ☐ YES Describe:____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated **Do you live alone?** ☐ NO ☐ YES

Home Environment: ☐ Apartment ☐ Private house
☐ Elevator ☐ Outside Steps ☐ Inside Stairs

Were you independent in your activities of daily living prior to your injury? ☐ NO ☐ YES If no, please describe:

____

FAMILY HISTORY: (Please list any medical problems in your relatives.)

Father:______________________ Mother:______________________ Siblings:____________________

Others:______________________ ____

OBSTETRICAL HISTORY (FOR FEMALES ONLY):

Are you currently pregnant? ☐ YES ☐ NO No. of Children:____ No. of Pregnancies:____ No. of Deliveries:____

REVIEW OF SYSTEMS (ROS)

Please indicate which, if any, of the following problems you have by circling YES or NO:

Constitutional		
Good general health	Yes	No
Recent weight change	Yes	No
Night sweats, fevers	Yes	No
Fatigue	Yes	No
Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Heart trouble	Yes	No
Swelling hands/feet	Yes	No
Musculoskeletal		
Muscle pain or cramps	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No
Endocrine		
Excessive thirst/urination	Yes	No
Hormone problem	Yes	No
Genitourinary - Male Only		
Blood in urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Testicle pain	Yes	No

Ears / Nose / Mouth / Throat		
Hearing loss or ringing	Yes	No
Sinus problems	Yes	No
Nose bleeds	Yes	No
Sore throat/voice change	Yes	No
Respiratory		
Shortness of breath	Yes	No
Cough	Yes	No
Coughing up blood	Yes	No
Neurological		
Frequent headaches	Yes	No
Paralysis or tremors	Yes	No
Numbness/tingling	Yes	No
Hematologic / Lymphatic		
Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No
Genitourinary - Female Only		
Blood in urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Menstrual problems	Yes	No

Eyes		
Wear glasses/contacts	Yes	No
Blurred/double vision	Yes	No
Eye disease or injury	Yes	No
Gastrointestinal		
Nausea/vomiting	Yes	No
Abdominal pain	Yes	No
Rectal bleeding	Yes	No
Bowel problems	Yes	No
Integumentary (Skin / Breast)		
Change in hair or nails	Yes	No
Rashes or itching	Yes	No
Breast lump	Yes	No
Breast pain or discharge	Yes	No
Allergic / Immunologic		
Food allergies	Yes	No
Aspirin allergies	Yes	No
Antibiotic allergies	Yes	No
Psychiatric		
Insomnia	Yes	No
Confusion/memory loss	Yes	No
Anxiety	Yes	No
Substance Abuse	Yes	No

CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY :
I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge.

Patient's or Responsible Party's Signature:______________________________ Date:__________

Patient's or Responsible Party's Signature:______________________________ Date:__________

CERTIFICATION BY PHYSICIAN:
I have reviewed the information contained in this Patient Assessment with the patient named within or Responsible Party who submitted the information in the Patient's behalf.

Physician's Signature:__________ Date:__________ Physician's Signature:__________ Date:__________

Physician's Signature:__________ Date:__________ Physician's Signature:__________ Date:__________

Temp__________ Pulse__________ ☐ Reg ☐ Irreg. Resp.__________