

# JENNINGS CLINIC, P.A.

Patient Name (print): \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Age \_\_\_\_\_  F  M Dominant hand  R  L Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Who requested that you visit this office?  Doctor (Name) \_\_\_\_\_  Self-referral  Attorney \_\_\_\_\_

1. \* **(Chief Complaint)** Main reason for visit?  Pain  Numbness  Weakness  Other \_\_\_\_\_

2. \* **(Location)** What body part is involved? (check below)

Neck <input type="checkbox"/>	and <input type="checkbox"/> R arm	Shoulder <input type="checkbox"/> R	Elbow <input type="checkbox"/> R	Hand <input type="checkbox"/> R	Pelvis <input type="checkbox"/> R	Knee <input type="checkbox"/> R	Foot <input type="checkbox"/> R
	radiates to <input type="checkbox"/> L arm	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L
Back <input type="checkbox"/>	and <input type="checkbox"/> R leg	Arm <input type="checkbox"/> R	Wrist <input type="checkbox"/> R	Finger <input type="checkbox"/> R	Hip <input type="checkbox"/> R	Ankle <input type="checkbox"/> R	Toe <input type="checkbox"/> R
	radiates to <input type="checkbox"/> L leg	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L

3. \* **(Duration)** How long has this problem been present? \_\_\_\_\_  Days  Weeks  Months  Years

4. Check the **ONE** box below that best describes how your problem started. The use the space to the right to answer the **ONE** question below the box you checked. Use as much space as needed.

**NO INJURY** (onset was:  Gradual or  Sudden)

Why do you think it started?

**INJURY** (from Accident or Sport **NOT** work or Auto)

Date \_\_\_\_\_, Where and how did it happen?

What sport \_\_\_\_\_ School \_\_\_\_\_

**INJURY AT WORK** (Date \_\_\_\_\_)

From a  lift  twist  bend  pull  reach

**WORK RELATED (BUT NO INJURY)**

Date \_\_\_\_\_, How did job cause this problem?

**AUTO ACCIDENT** (Date \_\_\_\_\_) How was car hit?

**ANSWER:      COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please check the box in each category that best describes your problem:**

5. \* **Severity** of pain?  Mild  Moderate  Severe  Extremely severe \_\_\_\_\_

6. \* **Quality** of pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning \_\_\_\_\_

7. **Timing** of pain?  Constant  Comes & goes (intermittent). Does pain wake you from **sleep**?  Yes  No

8. Do you have?  Swelling  Bruise  Numbness  Tingling  Weakness  Loss of bowel or bladder control

9. Since my problem started, it is:  Getting better  Getting worse  Unchanged \_\_\_\_\_

10. What makes your symptoms worse?  Standing  Walking  Lifting  Exercise  Twisting  Lying in bed

Bending  Squatting  Kneeling  Stairs  Sitting  Coughing  Sneezing

11. What makes it better?  Rest  Heat  Ice  Elevation  Other \_\_\_\_\_

12. What medications have you taken for this problem? \_\_\_\_\_

13. Which treatment have you tried?  Injection  Brace  Therapy  Cane/crutch

14. Were you seen in an Emergency Room for this problem?  N  Y Which ER and date? \_\_\_\_\_

15. What tests have you had?  X-rays  MRI  CAT scan  Bone scan  Nerve test (EMG/NCV)

16. Have you already had surgery for this problem?  N  Y Surgeons Name \_\_\_\_\_ date \_\_\_\_\_

**PAST MEDICAL HISTORY** (answering these questions helps the doctor effectively treat your current orthopaedic problem)

1. Do you take any prescription or non-prescription **MEDICATIONS**?  No  Yes (list below)

Medication	Dose	Medication	Dose

2. Are you **ALLERGIC** to any medications? No Yes, List \_\_\_\_\_

3. List other products that you are Allergic to (e.g. eggs, latex, iodine, etc). \_\_\_\_\_

4. Have you ever had **SURGERY**? No Yes (**Please List details below**)

<u>Surgery</u>	<u>Date</u>	<u>Surgery</u>	<u>Date</u>
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5. Did you have any adverse reactions to **anesthesia**? No Yes (please describe \_\_\_\_\_)

6. Do you have any **MEDICAL PROBLEMS**? NO Yes (please circle below or list)

Diabetes	High blood pressure	Heart problems	Blood clots	Asthma
Bronchitis	Emphysema	Kidney problems	Hepatitis	Thyroid disease
Ulcers	Seizures	Stroke	Tuberculosis	Rheumatoid arthritis
Cancer _____		Other _____		

**REVIEW OF SYSTEMS**

1. Have you ever had a prior problem with the same Orthopaedic condition you are here for today? N Y  
Do you have OTHER JOINTS with morning stiffness, swelling, or pain?

(Please check any that apply to you or mark **NONE**)

- 2. Heartburn Nausea Vomiting Blood in stool Stomach pain with anti-inflammatory pills  **NONE**
- 3. Excessive thirst Heat or cold intolerance
- 4. Weight loss fever Loss of appetite
- 5. Blurred vision Double vision Vision loss
- 6. Hearing loss Hoarseness Trouble swallowing
- 7. Chest pain palpitations
- 8. Chronic cough Shortness of breath
- 9. Painful urination Blood in Urine
- 10. Rash Skin ulcers Lumps Psoriasis
- 11. Headaches Dizziness
- 12. Depression Drug/Alcohol addiction Sleep disorder
- 13. Easy bleeding Easy bruising Anemia

**FAMILY HISTORY:**

Has any direct relative had any of the following? No Yes (please mark all that apply)

- Same Orthopaedic condition you are being seen for today Rheumatoid arthritis Diabetes
- High blood pressure Heart disease Reaction to anesthesia

**SOCIAL HISTORY**

Do you use tobacco? N Y Packs per day \_\_\_\_\_ Alcohol use? N Y How often? Daily Other \_\_\_\_\_

Marital history: M S D W

Occupation: \_\_\_\_\_ Student Employer \_\_\_\_\_

Are you currently working? Y N If NO, how long have you been off work? \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_