Kerlan - Jobe
Orthopaedic Clinic

PATIENT INFORMATION

(Please Print Legibly)

CHART # _____ **PHYSICIAN**_____ **DATE**_____

Patient Name (Last) _____ (First) _____ (Middle) _____

Social Security # _____ Driver's License #_____ State _____

Date of Birth: _____ Age: _____ Sex: ____ M ____ F Marital Status: __ S __ M __ D __ W

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State ____ Zip _____

Home # _____ Business # _____ Cell # _____

E-Mail _____

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Emergency Contact (other than home) _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Relationship _____

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Employer _____ **Occupation:** _____

Address _____

City _____ State _____ Zip _____ Phone# _____ ext _____

Employer (spouse) _____ **Occupation:**_____

Address _____

City _____ State _____ Zip _____ Phone# _____ ext _____

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INSURANCE

Primary: _____

Name of Insured _____

SS# _____

Date of Birth _____

Relationship 1=self, 2=spouse, 3=child, 4=other

ID#_____

Group Name _____

Group # _____

Secondary: _____

Name of Insured _____

Date of Birth _____

Relationship 1=self, 2=spouse, 3=child, 4=other

ID#_____

Group Name _____

Group # _____

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IF PATIENT IS A MINOR OR A STUDENT

School Name, Address and Phone # _____

Father's Name _____ Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work # _____ Ext _____

Mother's Name _____ Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work # _____ Ext _____

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PATIENT HISTORY

DATE _____

Patient Name: _____ DOB: _____ AGE: _____

Occupation: _____ SEX: ☐ M ☐ F

Doctor(s) who sent you: _____ Dominant Hand: ☐ Rt ☐ Lt

(CC) Reason for Visit: _____

DETAILS OF INJURY: WHERE, WHEN AND HOW INJURY OCCURED.

DATE OF INJURY _____ If not injury, give Date of Onset _____

Was injury or onset related to: Work: ☐ Y ☐ N Auto Accident: ☐ Y ☐ N

Other (school, sports, activity or explain) _____

How did injury or onset occur? _____

Where did the injury/problem occur? _____

What body parts were injured? _____

Any previous treatment of this problem? (include any medications prescribed)

Is this injury potentially going to be in litigation: Y N

Name of Physician(s) who treated you: When?

HISTORY OF PRESENT ILLNESS

A) LOCATION OF YOUR PAIN? (e.g. Low back, neck, groin, buttock, right or left knee, calf, right or left shoulder, right or left elbow, wrist, foot pain, heel, other)

B) SEVERITY OF YOUR PAIN? Mark the point on the line between 0 (least) and 10 (worst) which best describes how severe current pain is.

0 1 2 3 4 5 6 7 8 9 10

C) CHARACTER OF THE PAIN? (e.g.Dull, Sharp, Achy, Burning, Throbbing, Crampy, Dull, Shooting, Incapacitating, Prickly,sStabbing, other)

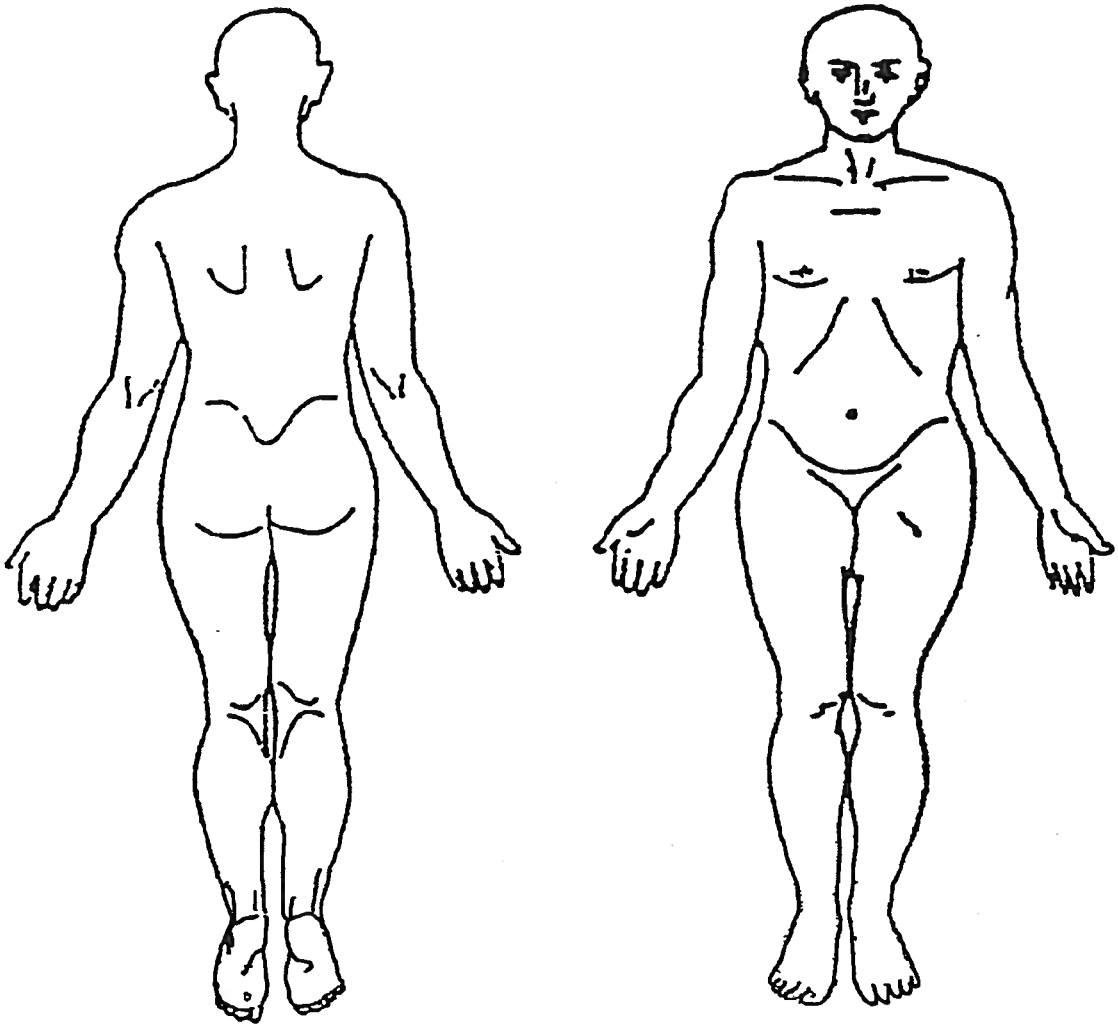
D) When do you feel pain and for how long does it last?

(Morning, Afternoon, Evening, Increases over the day, Bending, Climbing, Squatting. Is the pain Constant, How long does pain last?)

E) Associated Symptoms? (e.g. Swelling? , Locking, Giving Way, Tenderness, Fatigue, Bruising, Tingling, Numbness. Radiating Pain, Describe Where?)

F) What makes your symptoms better? (e.g.,Rest, Heat, Cold, Elevation, Physical Therapy, Braces, Injections, Special Positioning, Medications)

PAIN DRAWING Place x's at the location(s) of your worst pain using diagram below.



Patient Statement: To the best of knowledge, the above information is accurate and complete.

Signed: _____ Date: _____

Physican signature: _____ Date: _____

PATIENT HISTORY **DATE** _____

Past Hospitalizations/Surgeries/Injuries and Approximate Dates: ( ) **None:** _____

_____

_____

Current Medical History *Please circle Yes or No if you have any of the following medical problem?*

High Blood Pressure	Y	N	Diabetes	Y	N	Heart Trouble	Y	N
Respiratory Problems	Y	N	Stroke	Y	N	Cancer	Y	N
Bleeding Problems	Y	N	HIV/AIDS	Y	N	Other Problems	_____	
Pulmonary Embolism	Y	N	Blood Clot	Y	N	_____		
Gastrointestinal Problems	Y	N	Other	_____				

Current Medications: **NONE** ( )

MEDICATION NAME	DOSAGE	FREQUENCY

Allergies: ( ) None ( ) Contrast/Dye ( ) Sulfa ( ) Penicillin ( ) Local Anesthetics ( ) Latex ( ) Iodine ( ) Shellfish Other: _____

Family History: *Please list any FAMILY history medical problems: (i.g, Heart Disease, Stroke, Diabetes, Cancer)*

Father: _____ Mother: _____

Siblings: _____ Other: _____

Social History:

Marital Status: Single Married Separated Widowed Divorced Partner

Tabacco Use: Never Packs/day _____ How Many Years? _____ Quit/When _____

Alcohol Use: Never Rarely Moderate Daily How Much? _____

Drug Use: (Prescription & Non Prescription) Never Type & Frequency Recovery Program? Y N When?

Highest level of education: ( ) High School ( ) College ( ) Trade School ( ) Graduate School ( ) Professional School

REVIEW OF SYSTEMS (ROS) *Please circle Yes or No if you have any of the following problem?*

Constitutional			Ears/Nose/Mouth/Throat			Eyes		
Good General Health	N	Y	Hearing loss/ringing	N	Y	Wear glasses/contacts	N	Y
Recent Weight Change	N	Y	Sinus Problems	N	Y	Blurred/double vision	N	Y
Night Sweats, Fevers	N	Y	Nose Bleeds	N	Y	Eye disease or injury	N	Y
Fatigue	N	Y	Sore Throat/voice change	N	Y	Glaucoma	N	Y
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain	N	Y	Shortness of Breath	N	Y	Nausea/vomiting	N	Y
Palpitations	N	Y	Cough	N	Y	Abdominal Pain	N	Y
Heart Trouble	N	Y	Wheezing/Asthma	N	Y	Rectal bleeding	N	Y
Swelling hands/feet	N	Y	Coughing up Blood	N	Y	Bowel Problems	N	Y
Musculoskeletal			**Neurological**			**Integumentary (skin/breast)**		
Muscle pain or cramps	N	Y	Frequent headaches	N	Y	Change in hair or nails	N	Y
Stiffness/swelling joints	N	Y	Paralysis or tremors	N	Y	Rashes or itching	N	Y
Joint pain	N	Y	Convulsion/seizures	N	Y	Breast lump	N	Y
Trouble walking	N	Y	Numbness/tingling	N	Y	Breast pain or discharge	N	Y
Endocrine			**Hematologic/Lympathic**			**Allergic/Immunologic**		
Excessive thirst/urination	N	Y	Bruise easily	N	Y	Food Allergies	N	Y
Thyroid disease	N	Y	Slow to heal	N	Y	Aspirin Allergies	N	Y
Hormone Problem	N	Y	Enlarged glands	N	Y	Antibiotic Allergies	N	Y
Genitourinary-Male Only			**Genitourinary-Female Only**			**Psychiatric**		
Blood in urine	N	Y	Blood in urine	N	Y	Insomnia	N	Y
Kidney Stone	N	Y	Kidney Stone	N	Y	Confusion/memory loss	N	Y
Sexual problems	N	Y	Sexual problems	N	Y	Depression	N	Y
Testicular pain	N	Y	Menstrual problems	N	Y			