PERFORMANCE ORTHOPEDICS
Faster, Higher, Stronger

Justin L. Cashman, M.D.
Orthopedic Surgeon

Patient Medical History

Patient Name: ______________________________ Birth Date: ______________ Age: ________

Sex: __________ Occupation: ________________ **Right** *or* **Left** Handed? (please circle)

Date of Injury: ______________ Is this work Related? ( ) Yes ( ) No If so, was it reported? ( ) Yes ( ) No

Primary Care Physician: ______________________________ City: ______________

Referring Physician's Name: ___________________________ City: ______________

HISTORY OF PRESENT ILLNESS: **Problem with:** ( ) Right Extremity ( ) Left Extremity

Chief Complaint / Why are you here today?

____

____

____

Location: ____

(Where is the pain/problem? Does it travel to other areas?)

Quality: ____

(Is the pain dull, throbbing or sharp? If lump, is it warm, tender, red?)

Severity: ____________________________ **Duration:** ____________________________

(On a scale of 1-10 with 10 being the most severe?) *(How long have you had the problem?)*

Timing: ____________________________ **Context:** ____________________________

(Is the pain rare, intermittent or constant? Occur at a specific time?) *(What were you doing at the onset of the pain/ problem?)*

Associated signs/symptoms? ____

(popping, grinding, clicking, swelling, stiffness, instability, night pain, numbness, weakness?)

Modifying Factors: ____

(What make the pain or problem better or worse?)

Have you seen any other physicians regarding **this** condition prior to coming to our office? ( ) Yes ( ) No

Doctor	When	Tests	Results	Treatment

Please list any hobbies/ sports you enjoy: ______________________________________

Which of the above activities are you **unable** to perform due to your pain? ____________________

PAST SURGICAL HISTORY:

Date	Surgery	Date	Surgery

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PAST MEDICAL HISTORY: Have you ever had any of the following? (Please check all that pertain to you)

( ) High Blood Pressure	( ) AIDS or HIV +	( ) Fibromyalgia	( ) Pacemaker/Defibrillator
( ) Heart Disease	( ) Anemia	( ) Fractures ______________	( ) Parkinson's Disease
( ) Diabetes: ( ) I ( ) II	( ) Asthma	( ) Gout	( ) Polio
( ) Kidney Disease	( ) Back Problems	( ) Hepatitis	( ) Rheumatoid Arthritis
( ) Stomach Ulcers ( ) Reflux	( ) Bladder Infections	( ) High Cholesterol	( ) Sleep Apnea
( ) Blood Clot (DVT)	( ) Bleeding Tendency	( ) Infectious Mono	( ) Staph Infections (MRSA)
( ) Pulmonary Embolism	( ) Cancer ____________	( ) Irregular Heart Rhythm	( ) Stroke
( ) Thyroid Disease	( ) Epilepsy / Seizures	( ) Osteoporosis	( ) Other: ______________

ALLERGIES: *(medication & reaction)* ____

MEDICATIONS: *Please include prescriptions & non-prescription medications & herbal supplements (or attach a list)*

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

SOCIAL HISTORY:

Marital Status:		Alcohol Use:		Tobacco Use:	
( ) Single	( ) Divorced	( ) No	( ) Moderate	( ) Never	( ) Yes ______ packs/day
( ) Married	( ) Widowed	( ) Rare	( ) Daily	( ) Quit ____________ *(how long ago)*	

Family Medical History: Any family history of the following problems? *(please check all that pertain to you)*

( ) Cancer	( ) Arthritis	( ) Blood Clots (DVT or PE)
Specify: ____________	( ) Bleeding Tendency	( ) Heart Disease

REVIEW OF SYSTEMS: Please indicate *current* symptoms that you are having:

General	**Respiratory**	**Musculoskeletal**	**Psychiatric**
( ) Good General Health	( ) Shortness of Breath	( ) Joint Pain	( ) Depression
( ) Recent Weight Change	( ) Asthma / wheezing	( ) Joint Stiffness/ Swelling	( ) Sleep Disturbance
( ) Fever	**Gastrointestinal**	( ) Back Pain	**Endocrine**
Eyes	( ) Indigestion	( ) Muscle pain or Cramps	( ) Excessive Thirst
( ) Vision Changes	( ) Blood in Stool	( ) Difficulty Walking	( ) Excessive Urination
Ears, Nose & Throat	( ) Nausea / Vomiting	( ) Cold Extremities	**Hematologic**
( ) Hearing Loss	**Genitourinary**	**Neurological**	( ) Bleeding Tendency
( ) Bleeding Gums	( ) Incontinence	( ) Numbness	( ) Anemia
( ) Teeth Pain/ Cavities	( ) Frequent Urination	( ) Weakness	**Skin**
Cardiovascular	( ) Burning or Painful Urination	( ) Tremor	( ) Rash
( ) Chest Pain	( ) Difficulty w/ Urination	( ) Light Headed/ Dizzy	( ) Itching

To the best of my knowledge, the questions on this form have been answered correctly. I understand that it is my responsibility to inform the doctor of any changes in my medical condition.

____ ______________________

Signature of Patient, or Parent of Minor Date

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