

NAME: _____ TODAY'S DATE: _____

AGE _____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

OCCUPATION: _____ PRIMARY CARE PHYSICIAN: _____

ARE YOU RIGHT OR LEFT HANDED? _____

CHIEF COMPLAINT: SHOULDER ELBOW KNEE ANKLE
OTHER: _____

(please circle) RIGHT LEFT BOTH

REASON FOR VISIT: _____

WHEN DID YOUR SYMPTOMS START? _____

DID YOU HAVE A SPECIFIC INJURY? (please circle) YES NO

IF YES PLEASE DESCRIBE: _____

WAS THE INJURY WORK RELATED? (please circle) YES NO

ARE YOUR INJURIES RELATED TO A MOTOR VEHICLE ACCIDENT? (please circle) YES NO

HOW SEVERE IS YOUR PAIN (On a scale of 0-10 with 10 being the worst pain ever felt)? _____

TYPE OF PAIN: Dull Sharp Throbbing Achy Stabbing Shooting Other _____
(circle all that apply)

DOES YOUR PAIN AWAKEN YOU FROM SLEEP? (please circle) YES NO

DO YOU GET PAIN WITH (please circle):

Overhead Activities Throwing Lifting Carrying Reaching
Squatting Weight Bearing Activities At Rest Climbing Stairs

WHICH OF THE FOLLOWING SYMPTOMS IS THE MOST BOTHERSOME (please circle one):

Pain Weakness Stiffness Instability

Reviewed: _____

DO YOU GET ANY OF THE FOLLOWING (circle all that apply):

Weakness	Instability	Swelling	Clicking	Numbness	Night Pain
Stiffness	Loss of Range of Motion	Catching	Tingling	Neck Pain	

OTHER SYMPTOMS: _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM (circle all that apply):

X-rays	MRI	EMG	Physical Therapy	Ice	Heat	Medications	Injections
Surgery	Other _____						

PAST MEDICAL HISTORY: (Please circle Yes or No for the following medical conditions)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Stomach Problems	Yes	No
Latex Allergy	Yes	No	Thyroid Problems	Yes	No	Sleep Apnea	Yes	No
Hepatitis	Yes	No	Blood Clots	Yes	No	Other _____		

PAST SURGERIES AND APPROXIMATE DATES:

DRUG ALLERGIES: _____

CURRENT MEDICATIONS:

FAMILY HISTORY: (any medical problems in your blood relatives)

Mother: _____ Father: _____ Siblings: _____

SOCIAL HISTORY: Marital status: Single Married Separated Divorced Widowed

Tobacco Use: Never Currently Smoke, How many per day?_____ Quit/When:_____

Alcohol Use: Never Rarely Moderate Daily (how much):_____

Drug Use: Never Type and Frequency _____

REVIEW OF SYSTEMS: Do you have trouble with any of the following? (mark all that apply)

Headache	Eyesight	Hearing	Swallowing
Chest Pain	Shortness of Breath	Diarrhea	Constipation
Poor Circulation	Blood in Stool	Ulcers	Painful Urination
Leg Swelling	Night Sweats	Weight loss	Balance Rashes

Patient Signature: _____
(Or the person who is filling out this form)

Date: _____

Reviewed: _____

Sameer Nagda, MD
Sports Medicine and Shoulder Surgery
Anderson Orthopaedic Clinic
www.AndersonClinic.com

How did you hear about us?

We are always interested in knowing how our new patients heard about our practice. If you could please take a moment to let us know, we would greatly appreciate it! Thank you!!

I was referred by: (check all that apply)

- A primary care physician/ internal medicine or family practice physician
Name: _____
- An Orthopaedic Surgeon
Name: _____
- A Chiropractic physician
Name: _____
- A Physical Therapist
Name: _____
- A current or past patient of ours
Name: _____
- A Professional, Collegiate, or High School coach or trainer
Name: _____
- An Internet Website
Name: _____
- A newspaper advertisement or article
- An advertisement at a professional sporting event
- A Yellow pages ad/ Phonebook
- A worker's compensation referral
- Other: _____