Klamath Orthopedic and Sports Medicine Clinic

MRN:

Name: DOB: Today's Date:

Past Medical History

	Yes	No
AIDS/HIV	___	___
Alcoholism	___	___
Arthritis	___	___
Asthma	___	___
Blood Clots	___	___
Cancer	___	___
COPD	___	___
Diabetes		
*Type I	___	___
*Type II	___	___
Drug Abuse	___	___
Gout	___	___
Hypertension	___	___
Heart Disease	___	___
Hepatitis	___	___
Liver Disease	___	___
Kidney Disease	___	___
MRSA	___	___
RA	___	___
Stroke/TIA	___	___
Seizure	___	___
Thyroid Disease	___	___
Ulcers	___	___

Past Surgical History

	Yes	No	Year
Heart Bypass	___	___	____
Heart Stents	___	___	____
Hysterectomy	___	___	____
Joint Replaced	___	___	____
Spinal Surgery	___	___	____

*Please explain in space below

Medications

Circle if you are taking:

Aspirin
Coumadin
Plavix
Xarelto
Ibuprofen
Naproxen

Family History

	Yes	No	Relationship
Blood Clots	___	___	_____
Cancer	___	___	_____
Kidney Disease	___	___	_____
Liver Disease	___	___	_____
Stroke/TIA	___	___	_____
Thyroid Disease	___	___	_____

Explain all yes responses

_____

_____

Social History

	Yes	No
Do you live alone?	___	___
Do you use tobacco?	___	___
*Packs/cans per day?	_____	
*Quit date?	_____	

	Yes	No
Do you drink alcohol?	___	___
*How often?	_____	

	Yes	No
Do you use recreational drugs?	___	___
*How often?	_____	
* Which drugs?	_____	

Allergies

	Yes	No	Explain
Adhesive Tape	___	___	_____
Anesthetic	___	___	_____
Antibiotic	___	___	_____
Blood Thinner	___	___	_____
Latex	___	___	_____
Narcotics	___	___	_____
Shell Fish	___	___	_____
Other	_____		

Circle any that you have tried to relieve pain related to today's visit:

Acupuncture	Heat	Physical Therapy
Chiropractor	Injections	Repositioning
Cold	Medications	Rest

Other Health Information:

_____

_____

_____

MRN:

Appointment information

What are you being seen for today: _____

Rate your current pain level from 0-10: _____

How long have you had this pain: _____

	Yes	No
Is your condition the result of an incident/accident/injury?	___	___
Is your condition related to an auto incident/accident/injury?	___	___
Is your condition a work related incident/accident/injury?	___	___

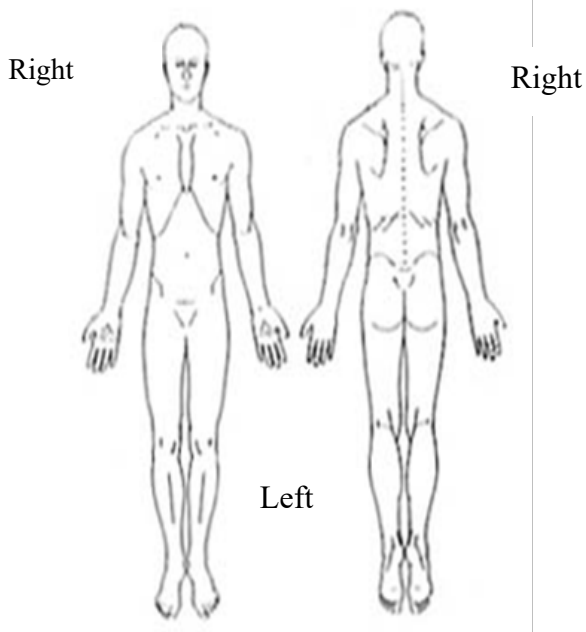
Explain all yes responses with a brief description of the incident/accident/injury:

_____

_____

_____

Please **circle** on the diagram the location of your pain.
Please mark with an **X** the location of any metal you may have in your body.
Please mark with **+** signs any areas of numbness you may have.



Medications

List all medications ☐ I do not take any home medications

Medication name	Dosage
Prescribed Medications	
Over the Counter Medication/Vitamins	

_____ _____

Signature Date