Name:
Chart:
Date:

## Southeastern Orthopaedic Specialists

Date:_____ Chart # _____ Provider _____

Patient Name (Please Print) _____

Patient Signature _____

BP ___/___ Pulse _____
Temp _____ H ___/___ W___

Date of Birth ___/___/___ Age ____ ☐ F ☐ M Height ___/___ Weight _____

Who requested that you visit this office? ☐ Doctor (Name) _____ ☐ Self-Referral ☐ Attorney _____

Primary Care Physician: _____

* What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other _____ (Chief Complaint)

*

| What body part is involved? (Location) | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neck ☐ | Shoulder | ☐ R ☐ L | Elbow | ☐ R ☐ L | Hand | ☐ R ☐ L | Pelvis | ☐ R ☐ L | Knee | ☐ R ☐ L | Foot | ☐ R ☐ L |
| Back ☐ Mid ☐ Lower | Arm | ☐ R ☐ L | Wrist | ☐ R ☐ L | Finger | ☐ R ☐ L | Hip | ☐ R ☐ L | ankle | ☐ R ☐ L | Toe | ☐ R ☐ L |

How long has this problem been present? _____ ☐ Days ☐ Weeks ☐ Months

Check the box which best fits how your problem started. Then answer the one question below the box you checked. Use as much space to the right as needed.

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden) **ANSWER:**
Why do you think it started? _____

**INJURY** - (NOT AUTO OR WORK) _____
Date _____, Where and How did it Happen? _____

**INJURY AT WORK** _____
Date _____, Where and How did it Happen? _____

**WORK RELATED - (BUT NO INJURY)** _____
Date _____, Where and How did it Happen? _____

**AUTO ACCIDENT** - Date / Details - _____
Driver / Passenger taken to ER? _____

Please check the box below which best describes your problem:

**The pain is** ☐ Constant ☐ Comes and goes (Intermittent) (Duration)

**Severity of pain** ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe (Severity)

What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other: _____ (Quality)

Are these associated symptoms? ☐ Swelling ☐ Numbness ☐ Weakness (Assoc Symp)

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged (Context)

Does your pain wake you from sleep? ☐ Yes ☐ No (Timing)

What makes your symptoms **worse**? ☐ Activity ☐ Exercise ☐ Work ☐ Other _____ (Modify)

Which make you feel better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____ (Modify)

What medications have you taken or been prescribed for this problem? _____ (Modify)

Check which treatments you have tried: Injection ☐ Y ☐ N Brace ☐ Y ☐ N Therapy ☐ Y ☐ N Cane/Crutch ☐ Y ☐ N (Modify)



^ Minimum dictation required for New/Consult Level 3,4,5 or Established Level 3,4,5
Recommended for all dictation levels for New, Consult or Established 1-5

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**REVIEW OF SYSTEMS**: Do you have now, or have you ever had, any of the following health problems?

N2E3 (MS) **1) M/S** • Have you had a prior problem with this same Orthopaedic condition in the past? ☐ Y ☐ N (explain below)

_____

• Have you had prior ☐ Back Pain ☐ Joint Swelling ☐ Prior Fracture ☐ Arthritis _____

N3E4 (2-9) **2) ARE YOU ALLERGIC TO ANY MEDICATIONS?** ☐ Y ☐ N If yes, please list _____

_____

**3) ARE YOU A DIABETIC?** ☐ Y ☐ N TREATMENT: ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

| (Please check all that apply, or mark None) | | None | Year | Explain Details/Comments |
|---|---|---|---|---|
| **4) CON** | ☐ weight loss ☐ Loss of appetite ☐ Fever ☐ Cancer | ☐ | | |
| N4,5 E5 (14) **5) EYE** | ☐ Glasses ☐ Contacts ☐ Double Vision ☐ Cataract | ☐ | | |
| **6) ENT** | ☐ Hearing Loss ☐ Hoarseness ☐ Ringing in Ears | ☐ | | |
| **7) CV** | ☐ High blood pressure ☐ Heart attack ☐ Blood clots | ☐ | | |
| **8) RS** | ☐ Asthma ☐ Cough ☐ Pneumonia ☐ Short of Breath ☐ TB | ☐ | | |
| **9) GI** | ☐ Stomach ulcer ☐ Hepatitis ☐ Blood in Stool | ☐ | | |
| **10) GU** | ☐ Pain with urination ☐ Blood in urine ☐ Kidney disease | ☐ | | |
| **11) SK** | ☐ Skin Ulcers ☐ Rash ☐ Lumps | ☐ | | |
| **12) NEU** | ☐ Seizures ☐ Stroke ☐ Balance Problem ☐ Headaches | ☐ | | |
| **13) PSY** | ☐ Depression ☐ Nervousness ☐ Sleep disorder ☐ Sleep Apnea | ☐ | | |
| **14) HEM** | ☐ Easy bleeding ☐ Easy bruising ☐ Anemia | ☐ | | |

**PAST MEDICAL HISTORY**

**LIST MEDICAL PROBLEMS:** _____

N3/E4 (1) * **WHAT MEDICATIONS DO YOU TAKE?** ☐ None Please list with dosage: _____

_____

N4,5 E5 (1) **ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BLOOD THINNERS?** Y N **If yes**, (type) _____

**PAST HOSPITALIZATIONS (Not for surgery)** ☐ **None** _____

**PAST SURGICAL HISTORY: What operations have you had? When?** ☐ None _____

_____

Have you ever had a reaction to anesthesia? ☐ Y ☐ N

N4,5 E5 (1) **FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?**

* Any direct relative with the same Orthopaedic condition you are being seen for today? ☐ Y ☐ N _____

Diabetes ☐ Y ☐ N _____ High Blood Pressure ☐ Y ☐ N _____ Heart disease ☐ Y ☐ N _____ Arthritis ☐ Y ☐ N ___

N4,5 E5 (1) **SOCIAL HISTORY:**

* Do you use tobacco? ☐ Y ☐ N **Packs per day** _____ Alcohol use? ☐ Y ☐ N How often? ☐ Daily ☐ Other _____ /week

Marital History: M S D W How many people live with you? _____

Occupation: _____ ☐ Student Employer: _____

Are you currently working? ☐ Y ☐ N If **no**, how long have you been off work? _____

For office use only

Reviewed for completeness by _____ Date ___/___/___ Reviewed by MD _____ Date ___/___/___

Reviewed by MD _____ Date ___/___/___ Reviewed by MD _____ Date ___/___/___

N3E4=Minimum dictation for New/Consult Level 3 or Estab. Level 4 N4,E5= Minimum dictation for New/Consult Level 4,5 or Estab. Level 5

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Authorization to release PHI (Personal Health Information)

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to release my PHI to:
(EXCLUDES PHYSICIANS & ATTORNEYS)

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Name of person that information may be released to:
(i.e. spouse, parent, guardian, sibling, etc.)

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Address

Patient's Name: _____ Date of Birth: _____

Address: _____

Patient's Signature: _____ Date: _____

Relationship to Patient: _____

Type of information that may be released:
(financial, medical information, information for a specific problem)

Expiration Date: _____

To revoke this authorization, it must be submitted in writing to Southeastern Orthopaedic Specialists, P.A.

There is potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI (Personal Health Information).