

CALIFORNIA ORTHOPAEDIC SPECIALISTS

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PATIENT INFORMATION DATA

DATE _____

NAME _____

AGE _____ HEIGHT _____ WEIGHT _____

DOMINANCE: RIGHT: _____ LEFT: _____ AMBIDEXTROUS: _____

PRESENT HISTORY: CHECK CORRECT ITEM OR FILL IN THE BLANKS

MY PRESENT PROBLEM IS WITH MY: RIGHT _____ LEFT _____

_____ KNEE _____ SHOULDER _____ ELBOW _____ WRIST _____ HIP

_____ FOOT/TOES _____ ANKLE _____ HAND/FINGERS _____ OTHER

WHEN DID THE PRESENT PROBLEM START? _____

HAS BEEN WORSENING SINCE? _____

THE PROBLEM BEGAN: _____ GRADUALLY _____ SUDDENLY

THE PROBLEM BEGAN AT HOME _____

AT WORK _____

WITH AN ACCIDENT _____

THE PROBLEM BEGAN: _____ WHEN I FELL _____ AT THE TIME OF THE ACCIDENT

_____ DURING OR AFTER LIFTING/BENDING _____ FOR NO APPARENT REASON

ACCIDENT/INJURY DATA:

DATE _____

LOCATION _____

SPECIFICS _____

MEDICAL ATTENTION _____

IF MVA: SEAT BELT / SHOULDER HARNESS: _____ ON _____ OFF

PRESENT COMPLAINTS:

DO YOU HAVE PAIN? _____ YES _____ NO

WHERE? _____

IS YOUR PAIN: _____ CONSTANT _____ DULL _____ ACHING _____ STABBING _____ BURNING

DO YOU HAVE RADIATING PAIN? _____

DO YOU HAVE NUMBNESS OR TINGLING? _____

DO YOU HAVE ANY WEAKNESS? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT MAKES YOUR PAIN BETTER? _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS: _____ STIFFNESS _____ SPASMS

_____ SWELLING _____ GRINDING _____ LOCKING _____ GIVING WAY _____ POPPING

_____ UNABLE TO BEND OR FLEX YOUR JOINT _____ OTHER _____

WHAT TREATMENT HAVE YOU USED? (i.e., heat, ice, medicine): _____

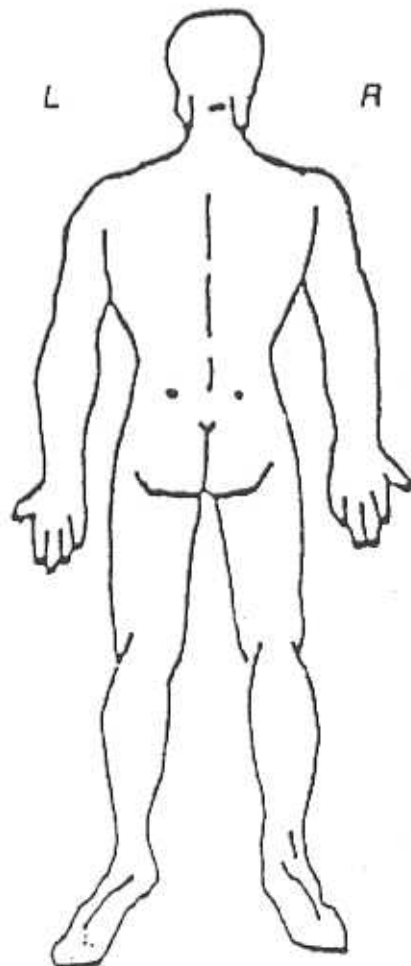
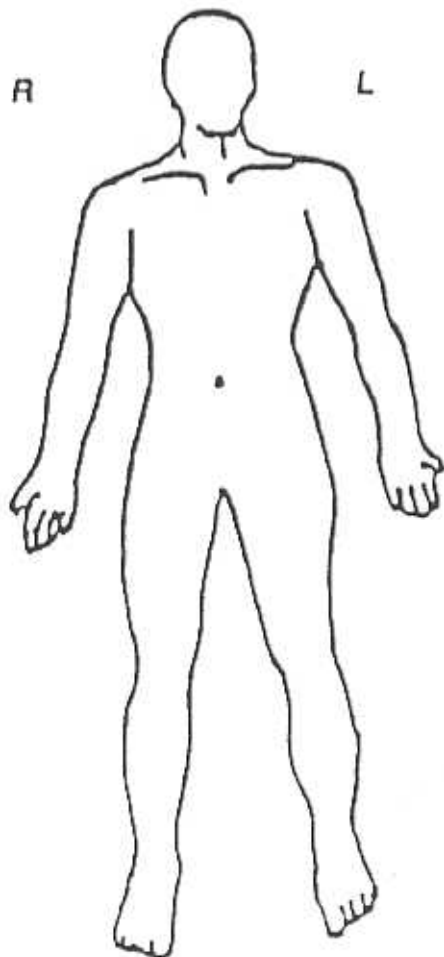
HAVE YOU EVER HAD AN INJURY OR SIMILAR SYMPTOMS TO THE SAME AREA OF YOUR BODY

PRIOR TO THIS ILLNESS/INJURY _____ YES _____ NO

IF YES, EXPLAIN:

PAIN DRAWING:

MARK AREAS ON THE FOLLOWING DRAWINGS WHERE YOUR PAIN IS:



EMPLOYMENT HISTORY

Present employer: _____

How long: _____

Present job/occupation: _____

My present/last job involves(d): (Check all that apply)

	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Lifting	_____ lbs.	_____ lbs.	_____ lbs.
Bending	_____	_____	_____
Twisting	_____	_____	_____
Sitting	_____ hrs.	_____ hrs.	_____ hrs.
Standing	_____ hrs.	_____ hrs.	_____ hrs.
Walking	_____ hrs.	_____ hrs.	_____ hrs.
Driving	_____ hrs.	_____ hrs.	_____ hrs.

IF UNEMPLOYED OR NOT CURRENTLY WORKING:

Retired: ___ Yes ___ No

On medical leave: ___ Yes ___ No Since: _____

Laid off: ___ Yes ___ No Since: _____

On total disability: ___ Yes ___ No Since: _____

SSD: ___ Yes ___ No Next review: _____

I last worked on: _____

My employer would allow me to return to work with restrictions: ___ Yes ___ No

ACTIVITIES

What sports-related, physical activities or hobbies to you engage in?

Aerobics _____	Swimming _____
Step aerobics _____	Bicycle riding _____
Walking _____	Karate _____
Golf _____	Volleyball _____
Tennis _____	Basketball _____
Baseball _____	Football _____
Track _____	Other _____
Jogging _____	_____

Have you been limited in these activities?

Yes ___ No ___ How? _____

Other activities in which you have participated:

Dancing _____	Gardening _____
Yard work _____	Carpentry _____
Other _____	_____