

# CALIFORNIA ORTHOPAEDIC SPECIALISTS

360 San Miguel, Suite 701  
Newport Beach, California 92660  
Telephone (949) 759-3600  
FAX (949) 759-5017

Ralph J. Venuto, M.D.  
Michael P. Weinstein, M.D.

Scott K. Forman, M.D.  
Nicholas E. Rose, M.D.  
Stephen A. Mikulak, M.D.

## 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): \_\_\_\_\_

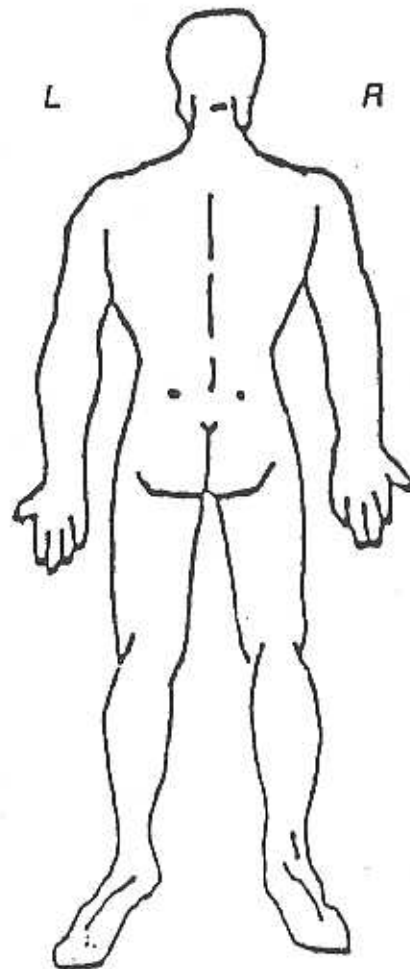
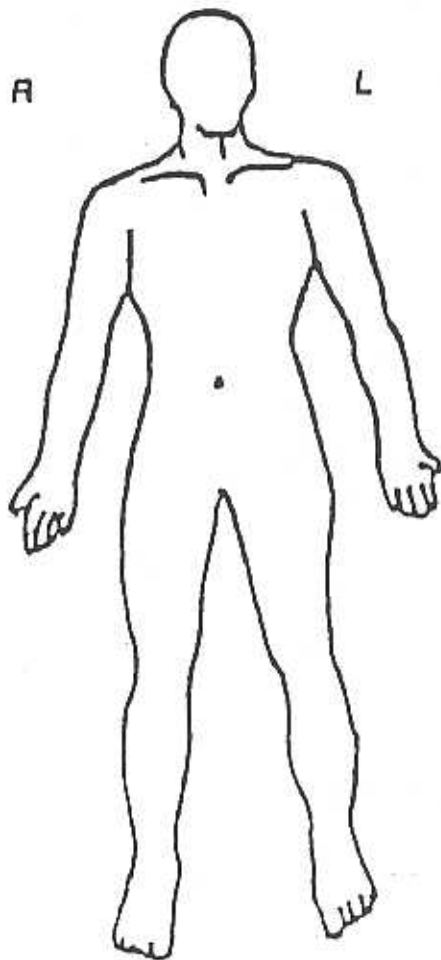
HAVE YOU EVER HAD AN INJURY OR SIMILAR SYMPTOMS TO THE SAME AREA OF YOUR BODY

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 _____	_____