

## Cornerstone Orthopedics & Sports Medicine, P.C

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did a doctor refer you to Cornerstone? If so, Doctor/Provider name: \_\_\_\_\_

Reason for today's visit (briefly describe): \_\_\_\_\_

Circle the following area that we will be evaluating today: (Circle Left or Right where applicable)

L R Shoulder	L R Fingers	L R Thigh	L R Ankle
L R Arm	L R Wrist	L R Toes	L R Foot
L R Elbow	L R Hand	L R Knee	Neck/Cervical Spine
L R Forearm	L R Hip	L R Leg	Upper Back/Thoracic Spine
			Low Back/Lumbar Spine

<b>SEVERITY</b>	<input type="checkbox"/> Mild	<input type="checkbox"/> Mild/Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate/Severe	<input type="checkbox"/> Severe	<input type="checkbox"/> Other _____
<b>STATUS</b>	<input type="checkbox"/> Unchanged	<input type="checkbox"/> Improving	<input type="checkbox"/> Fluctuating	<input type="checkbox"/> Stable	<input type="checkbox"/> Worse	<input type="checkbox"/> Other _____

### PAIN QUALITY

<input type="checkbox"/> Aching	<input type="checkbox"/> Numbness
<input type="checkbox"/> Burning	<input type="checkbox"/> Sharp
<input type="checkbox"/> Dull	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Other _____	

### CONTEXT

<input type="checkbox"/> No Injury	Date of Onset _____
<input type="checkbox"/> Injury--	Date of Injury _____
<input type="checkbox"/> Sports Injury--	
<input type="checkbox"/> Motor Vehicle Accident	

### AGGRAVATED BY Nothing

<input type="checkbox"/> Bending	<input type="checkbox"/> Flexion	<input type="checkbox"/> Sitting
<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Lifting	<input type="checkbox"/> Standing
<input type="checkbox"/> Descending stairs	<input type="checkbox"/> Movement	<input type="checkbox"/> Walking
<input type="checkbox"/> Extension	<input type="checkbox"/> Pushing	<input type="checkbox"/> Other _____

### RELIEVED BY Nothing

<input type="checkbox"/> Brace/Splint	<input type="checkbox"/> Ice	<input type="checkbox"/> Pain/Rx Meds
<input type="checkbox"/> Elevation	<input type="checkbox"/> Injection	<input type="checkbox"/> Mobility
<input type="checkbox"/> Exercise	<input type="checkbox"/> Massage	<input type="checkbox"/> OTC Meds
<input type="checkbox"/> Heat		<input type="checkbox"/> Rest

### ASSOCIATED SYMPTOMS

<input type="checkbox"/> Bruising	<input type="checkbox"/> Locking	<input type="checkbox"/> Swelling
<input type="checkbox"/> Instability	<input type="checkbox"/> Night Pain	<input type="checkbox"/> Tingling
<input type="checkbox"/> Limping	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tenderness
<input type="checkbox"/> Decreased Mobility	<input type="checkbox"/> Popping	<input type="checkbox"/> Weakness

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pain Scale: (please rate the pain/discomfort on scale of 1 to 10 with 10 being worst) \_\_\_\_\_ /10

Preferred Pharmacy: (ie: Walgreens 120<sup>th</sup>/Sheridan) \_\_\_\_\_ City: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies & Reaction: (Drug / Latex / Nickel) \_\_\_\_\_  No Allergies

### Review of Systems (Please check all that currently apply)

All Systems Normal

<b>CONSTITUTIONAL</b>	<b>CARDIOVASCULAR</b>	<b>INTEGUMENTARY</b>	<b>METABOLIC/ENDOCRINE</b>
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rash	<input type="checkbox"/> Cold Intolerant
<input type="checkbox"/> Fever	<input type="checkbox"/> Discoloration--Cyanosis		<input type="checkbox"/> Heat Intolerant
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Irregular heartbeat/palpitations	<b>NEUROLOGICAL</b>	<b>PSYCHIATRIC</b>
	<b>GASTROINTESTINAL</b>	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Anxiety
<b>HEAD/EAR/NOSE/THROAT</b>	<input type="checkbox"/> Constipation	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression
<input type="checkbox"/> Headache	<input type="checkbox"/> Diarrhea		<b>HEMATOLOGIC</b>
<input type="checkbox"/> Vision loss	<input type="checkbox"/> Vomiting	<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> Bleeding
	<b>GENITOURINARY</b>	<input type="checkbox"/> Other than today's reason for visit. Please explain: _____	<input type="checkbox"/> Bruising
<b>RESPIRATORY</b>	<input type="checkbox"/> Painful urination--Dysuria		<b>IMMUNOLOGICAL</b>
<input type="checkbox"/> Cough	<input type="checkbox"/> Blood in urine--Hematuria		<input type="checkbox"/> Environmental Allergies
<input type="checkbox"/> Difficulty breathing--Dyspnea	<input type="checkbox"/> Incontinence		<input type="checkbox"/> Food Allergies

Please Complete Reverse Side

Print Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Past Medical History** (Please check all that apply or list below)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Peptic ulcer disease
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Inflammatory Bowel disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Juvenile Rheumatoid Arthritis	<input type="checkbox"/> PVD-peripheral vascular disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Renal disease
<input type="checkbox"/> Angina—chest pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> DVT—Blood Clots	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Benign enlarged prostate	<input type="checkbox"/> Gall bladder disease	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> SLE—Systemic lupus
<input type="checkbox"/> Cancer—specify:	<input type="checkbox"/> GERD	<input type="checkbox"/> Obesity	<input type="checkbox"/> Spinal Stenosis
<input type="checkbox"/> CVA-stroke	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Spondyloarthropathy
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> COPD	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Valvular disease

Other Medical History: \_\_\_\_\_

**Past Surgical History** (Please check all that apply and indicate year of surgery or list below)

	Year		Year		Year		Year
<input type="checkbox"/> ACL Surgery		<input type="checkbox"/> Back surgery		<input type="checkbox"/> Hernia repair		<input type="checkbox"/> Rotator cuff repair	
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> CABG—coronary artery bypass		<input type="checkbox"/> Hip Arthroplasty		<input type="checkbox"/> Small bowel resection	
<input type="checkbox"/> Angio w/ stent		<input type="checkbox"/> Cardiac valve replacement		<input type="checkbox"/> Hip replacement		<input type="checkbox"/> Thyroidectomy	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Carpal tunnel release		<input type="checkbox"/> Knee replacement		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Arthroscopy ankle		<input type="checkbox"/> Cataract extraction		<input type="checkbox"/> Laminectomy		<b>Gender Specific:</b>	
<input type="checkbox"/> Arthroscopy elbow		<input type="checkbox"/> Cholecystectomy		<input type="checkbox"/> LASIK		<input type="checkbox"/> Cesarean section	
<input type="checkbox"/> Arthroscopy hip		<input type="checkbox"/> Colectomy		<input type="checkbox"/> Meniscus surgery		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Arthroscopy knee		<input type="checkbox"/> Colostomy		<input type="checkbox"/> Muscle biopsy		<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> Arthroscopy wrist		<input type="checkbox"/> Discectomy		<input type="checkbox"/> ORIF—fracture fixation		<input type="checkbox"/> Prostate surgery	
<input type="checkbox"/> Arthroscopy shoulder		<input type="checkbox"/> Gastric bypass		<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Urological surgery	

Other Surgical History: \_\_\_\_\_

**Family History**

	Living	Deceased	Age	Health Conditions (list any conditions, i.e., Past Medical History section)
Mother				
Father				
Brother (s)				
Sister (s)				
Other Pertinent Family History:				

**Social History**

Hand Dominance: (Circle one) Right / Left / Both Marital Status: Single / Married / Divorced / Separated / Widowed / Co-habitation

Activity Level: Sedentary / Moderate / Vigorous / Competitive Athlete Type(s) of Exercise: \_\_\_\_\_

Exercise Frequency: \_\_\_\_\_ Hours/week: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Tobacco Use? Y N If yes, Type? \_\_\_\_\_ How much per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Have you tried to quit Y N If you are a former tobacco user, what year did you quit? \_\_\_\_\_

Do you drink Alcohol? Y N Type: \_\_\_\_\_ Amount per week: \_\_\_\_\_

Occupation: \_\_\_\_\_

Please Complete Reverse Side