COMPREHENSIVE ORTHOPAEDIC GLOBAL

NEW PATIENT **BUBBLE SHEET**

PLEASE DARKEN THE BUBBLES COMPLETELY!

PATIENT **INFORMATION**

Patient Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Referring Physician: _____ Pharmacy: _____

I. Problem involves the:

❍ Neck ❍ Mid Back ❍ Low Back ❍ Head ❍ Right Wrist ❍ Left Wrist ❍ Right Shoulder
❍ Left Shoulder ❍ Right Elbow ❍ Left Elbow ❍ Right Hand ❍ Left Hand ❍ Right Hip ❍ Left Hip
❍ Right Thigh ❍ Left Thigh ❍ Right Ankle ❍ Left Ankle ❍ Right Knee ❍ Left Knee ❍ Right Calf
❍ Left Calf ❍ Right Foot ❍ Left Foot

II. Is this problem work related? ❍ Yes ❍ No If so, what is the date of injury: _____

III. Is this injury the result of a motor vehicle accident? ❍ Yes ❍ No

IV. Please give an approximate time (date, month, or year) when the symptoms began: _____

V. Describe the injury and/or development of your problem: _____

Pain Scale: On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain you are experiencing?

❍ 0/10 ❍ 1/10 ❍ 2/10 ❍ 3/10 ❍ 4/10 ❍ 5/10 ❍ 6/10 ❍ 7/10 ❍ 8/10 ❍ 9/10 ❍ 10/10

MEDICAL **HISTORY**

❍ Osteoporosis ❍ Poor Circulation ❍ Ulcers ❍ High Blood Pressure ❍ Cancer ❍ Anemia
❍ Diabetes ❍ Heart Disease ❍ Treated for Drug or Alcohol Addiction ❍ Arthritis ❍ Kidney Disease

Occupation: _____

Work Status: ❍ Full Duty ❍ Light Duty ❍ Unemployed ❍ Retired ❍ Disabled ❍ Student

Do you use tobacco products? ❍ Yes ❍ No

What products? ❍ Cigarettes ❍ Cigars ❍ Chewing Tobacco

How long have you used them? ❍ 1 year ❍ 1-10 years ❍ 0+ years

Quantity per day? ❍ 1 pack/can ❍ 1-2 packs/cans ❍ 3+ packs/cans ❍ 2 Cigars

Do you drink alcohol regularly? ❍ Yes ❍ No ❍ Socially

How many drinks per day? ❍ 2 drinks ❍ 3-5 drinks ❍ 6+ drinks

FAMILY **HISTORY**

Mother	❍ Bleeding Disorders/Clots	❍ Diabetes	❍ Heart Attack/Stroke	❍ Hypertension	❍ Arthritis
Father	❍ Bleeding Disorders/Clots	❍ Diabetes	❍ Heart Attack/Stroke	❍ Hypertension	❍ Arthritis
Grandparents	❍ Bleeding Disorders/Clots	❍ Diabetes	❍ Heart Attack/Stroke	❍ Hypertension	❍ Arthritis
Siblings	❍ Bleeding Disorders/Clots	❍ Diabetes	❍ Heart Attack/Stroke	❍ Hypertension	❍ Arthritis

CONSTITUTIONAL **SYSTEMS**

Fever: ❍ Yes ❍ No **Headache:** ❍ Yes ❍ No **Chills:** ❍ Yes ❍ No **Weight Loss/Gain:** ❍ Yes ❍ No

EYES

Blurred Vision: ❍ Yes ❍ No Double Vision: ❍ Yes ❍ No Eye Pain : ❍ Yes ❍ No

RESPIRATORY

Cough: ❍ Yes ❍ No Sputum: ❍ Yes ❍ No Palpitations: ❍ Yes ❍ No

CARDIOCASCULAR

Chest Pain: ❍ Yes ❍ No Shortness of Breath: ❍ Yes ❍ No Palpitations: ❍ Yes ❍ No

GASTROINTESTINAL

Abdominal Pain: ❍ Yes ❍ No Nausea & Vomiting : ❍ Yes ❍ No Indigestion: ❍ Yes ❍ No

Dark Stool: ❍ Yes ❍ No

GENITOURINARY

Urine Retention: ❍ Yes ❍ No Urinary Frequency: ❍ Yes ❍ No Pain with Urination: ❍ Yes ❍ No

MUSCUOLOSKELETAL

Joint Pain: ❍ Yes ❍ No Morning Stiffness: ❍ Yes ❍ No Muscle Cramps: ❍ Yes ❍ No

SKIN

Rashes: ❍ Yes ❍ No Easy Bruising: ❍ Yes ❍ No Easy Bleeding: ❍ Yes ❍ No

NEUROLOGICAL

Dizzy Spells: ❍ Yes ❍ No Tremor: ❍ Yes ❍ No Numbness: ❍ Yes ❍ No

ENDOCRINE

Excessive Thirst: ❍ Yes ❍ No Tired/Sluggish: ❍ Yes ❍ No Too Hot/Cold: ❍ Yes ❍ No

Patient Signature: _____ Date:_____