Wenatchee Valley Medical Center Orthopedics
Patient Information

Place label here.

Age:_____ Occupation:_____
Hand Domination: Right_____ Left_____
Please indicate current problem:_____
_____
Date of Injury:_____ L&I#_____
Referred by: Self_____ or Dr. _____
Is this condition work related? Yes No
Have you ever received treatment for this condition? Yes No
If so, what prior treatments have been instituted?
_____
(For example: medications, x-rays, injections, surgery, physical therapy and/or chiropractic.)

Females: Are you pregnant? Yes No

List all allergies as of this date to medications:
1. _____
2. _____

To be filled out by nurse

Wt._____ Ht_____
BP_____
Temp_____ P_____ RR_____
_____

Surgical History (Please circle Yes or No)

Ankle fracture surgery	Yes	No	Foot surgery	Yes	No	Knee surgery	Yes	No
Back surgery	Yes	No	Hand surgery	Yes	No	Laminectomy (spine surgery)	Yes	No
Carpal tunnel release	Yes	No	Hip surgery	Yes	No	Shoulder arthroscopy	Yes	No
Elbow fracture surgery	Yes	No	Humerus fracture surgery	Yes	No	Shoulder surgery	Yes	No
Elbow surgery	Yes	No	Joint replacement surgery	Yes	No	Spinal fusion	Yes	No
Femur fracture surgery	Yes	No	Knee arthroscopy	Yes	No	Wrist fracture surgery	Yes	No
Foot fracture surgery	Yes	No	Abdomen surgery	Yes	No	Heart surgery	Yes	No
						Other: _____		

Past Medical History (please circle Yes or No)

Asthma	Yes	No	Cancer	Yes	No	Diabetes mellitus	Yes	No
Hepatitis	Yes	No	Hypertension	Yes	No	Heart problems	Yes	No
Kidney Disease	Yes	No	Pneumonia	Yes	No	Rheumatoid arthritis	Yes	No
Seizures	Yes	No	Stroke	Yes	No	Ulcers	Yes	No
						Other: _____		

Family History (please check those that apply)

Relationship	Name	Living	Arthritis	Bleeding Problems	Cancer	Diabetes	Heart disease	Kidney disease	Rheumatoid arthritis	Stroke
Mother										
Father										
Sister										
Brother										
MGrandmother										
MGrandfather										
PGrandmother										
PGrandfather										

Other: _____

Social History - Substance History

Alcohol Use	Yes	No	Drinks per week ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy
Drug Use	Yes	No	Comments: _____
Tobacco Use	Yes	No	Packs/Day _____ Years of smoking _____ Quit date: _____
Smokeless Tobacco	Yes	No	Quit date: _____ Comment: _____

List all medications you are currently taking:

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Pain Assessment (Circle all that apply)	
Location of Pain	Ankle Arm Back Buttocks Coccyx Elbow Finger Foot Hand Jaw Knee Leg Neck Pelvis Rib Cage Shoulder Sternum Toe Wrist
Location	Left Right
Severity of Pain	0 1 2 3 4 5 6 7 8 9 10
Quality of Pain	Throbbing Sharp Dull Aching Locking Grinding Popping Cracking Buckling Burning Other: _____
Current symptoms	Swelling Stiffness Weakness Pain at Night Numbness Warmth Tingling Instability Other _____
Duration of Pain	A few minutes A few hours A few days Persistent Other: _____
Frequency of Pain	Rarely Once/Week Several days/Week Several times daily Intermittent Constant Other _____
Date Pain First Started	
Aggravating Factors	Bending Stretching Straightening Exercise Kneeling Squatting Standing Walking Stairs Other _____
Limiting Behavior	Yes No Some
Relieving Factors	Rest Ice Heat Exercise NSAIDS Other: _____
Result of Injury	Yes No
Work-Related Injury	Yes No
Do you use:	Cane Walker Wheelchair Braces
Are there other pain locations you wish to document?	Yes No Comments, if Yes: _____

REVIEW OF SYSTEMS: Do you <u>currently</u> have any of these symptoms?

Please circle either YES or NO for each condition.

Constitutional		
Fever	Yes	No
Chills	Yes	No
Weight Loss	Yes	No
Weakness	Yes	No

Skin		
Rash	Yes	No
Itching	Yes	No

Head/Ears/Nose/Throat		
Headaches	Yes	No
Hearing Loss	Yes	No
Congestion	Yes	No
Noisy Breathing	Yes	No
Sore Throat	Yes	No

Eyes		
Blurred Vision	Yes	No
Double Vision	Yes	No

Cardiovascular		
Chest Pain	Yes	No
Shortness of Breath	Yes	No
Lower Leg Pain	Yes	No
Leg Swelling	Yes	No

Respiratory		
Cough	Yes	No
Short of Breath	Yes	No
Wheezing	Yes	No

Gastrointestinal		
Heartburn	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Abdominal Pain	Yes	No

Urogenital		
Painful Urination	Yes	No
Blood in Urine	Yes	No

Musculoskeletal		
Muscle Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No
Joint Pain	Yes	No
Falls	Yes	No

Endocrine/Heme/Allergies		
Easy Bruise/bleed	Yes	No
Environmental Allergies	Yes	No

Neurological		
Dizziness	Yes	No
Tingling	Yes	No
Sensory Change	Yes	No
1-Sided Weakness	Yes	No
Seizures	Yes	No
Loss of Consciousness	Yes	No

Psychiatric		
Depression	Yes	No
Substance Abuse	Yes	No
Nervous/Anxious	Yes	No
Memory Loss	Yes	No

Are you currently being treated for any of the above conditions? Yes No