Klamath Orthopedic and Sports Medicine Clinic

Name: DOB: Today's Date:

Past Medical History

	Yes	No
AIDS/HIV	___	___
Alcoholism	___	___
Arthritis	___	___
Asthma	___	___
A FIB	___	___
Blood Clots	___	___
Cancer	___	___
COPD	___	___
Diabetes		
Type 1	___	___
Type 2	___	___
Drug Abuse	___	___
Gout	___	___
Hypertension	___	___
Heart Disease	___	___
Hepatitis	___	___
Liver Disease	___	___
Kidney Disease	___	___
MRSA	___	___
RA	___	___
Sleep Apnea	___	___
Stroke/TIA	___	___
Seizure	___	___
Thyroid Disease	___	___
Ulcers	___	___

Past Surgical History

	Yes	No
Heart Bypass	___	___
Heart Stents	___	___
Hysterectomy	___	___
Joint Replaced	___	___
Pacemaker	___	___
Spinal Surgery	___	___

Medications

	Yes	No
Aspirin	___	___
Coumadin	___	___
Heparin	___	___
Plavix	___	___
Xarelto	___	___
Ibuprofen	___	___
Naproxen	___	___

Family History

	Yes	No	Relationship
Blood Clots	___	___	___________
Cancer	___	___	___________
Kidney Disease	___	___	___________
Liver Disease	___	___	___________
Stroke/TIA	___	___	___________
Thyroid Disease	___	___	___________

Social History

	Yes	No
Do you live alone?	___	___
Do you:		
Use tobacco?	___	___
Cigarettes?	___	___
Oral/Chew?	___	___
Packs/cans per day?	___________	
Quit Date?	___________	
Drink alcohol?	___	___
How often?	___________	
Use recreational drugs?	___	___
How often?	____________________	
Which drugs?	____________________	

Allergies

	Yes	No	Reaction
Adhesive Tape	___	___	____________
Anesthetic	___	___	____________
Antibiotics	___	___	____________
Blood Thinners	___	___	____________
Latex	___	___	____________
Narcotics	___	___	____________
Shellfish/Iodine	___	___	____________
Other	___	___	____________

What conservative treatment have you used to relieve pain related to today's visit? (I.E. acupuncture, heat/cold, physical therapy, chiropractor, injections, repositioning, medications, rest)

____

____

Pain Management

Are you currently taking any pain medications? Yes No

If Yes, which clinic/provider prescribes you medication?

____

Appointment information

What are you being seen for today: ____

Rate your current pain level from 0-10: ____

How long have you had this pain: ____

	Yes	No
Is your condition accident related?	___	___
Did you injure yourself while at work?	___	___
Did you injure yourself while in or around a motor vehicle?	___	___

Explain all yes responses with a brief description of the incident/accident/injury:

____

____

____

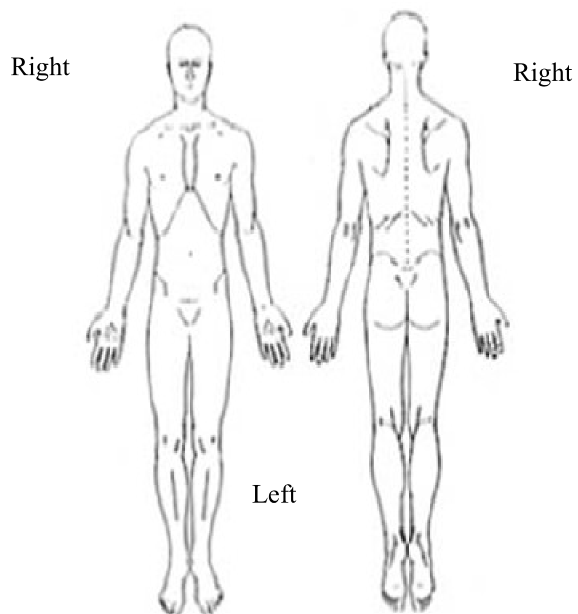
Medications

List all medications ☐ I do not take any medications

Medication name	Dosage and frequency

Preferred Pharmacy ______________________________

Please **circle** on the diagram the location of your pain.
Please mark with an **X** the location of any metal you may have in your body.
Please mark with **+** signs any areas of numbness you may have.



X______________________________________

Signature

X________________________

Date