OrthoMA
ORTHOPEDIC URGENT CARE

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HISTORY AND PHYSICAL EXAMINATION

Date _____ Acct # _____

Patient's Name _____ Date of Birth _____

Primary Care Doctor _____ Referral Doctor (if different) _____

Reason for Visit (Chief Complaint) _____

_____

Date of first symptoms _____ MVA ☐ Work related ☐ _____
Date of Injury

PAST MEDICAL HISTORY:

_____

_____

_____

SURGICAL PROCEDURES: **Date**

_____

_____

_____

REVIEW OF SYSTEMS: *(Check all that apply)*

Yes	No		Yes	No		Yes	No	
☐	☐	Headaches	☐	☐	Stomach, ulcer, intestinal problems	☐	☐	Anemia
☐	☐	Seizures	☐	☐	Cholesterol	☐	☐	Cancer
☐	☐	Strokes	☐	☐	Breathing or lung disorders.	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	Sleep Apnea	☐	☐	Phlebitis or blood clots
☐	☐	Nerve disorders	☐	☐	Kidney/Bladder problems	☐	☐	Ease of bruising
☐	☐	Circulation problems.	☐	☐	Thyroid problems.	☐	☐	Bleeding disorder.
☐	☐	Heart trouble	☐	☐	Diabetes	☐	☐	Emotional or psychiatric difficulties
☐	☐	High blood pressure	☐	☐	Lyme Disease	☐	☐	Other medical problems
☐	☐	Inflammatory joint disease	☐	☐	HIV/Aids			

MEDICATION USAGE:

Med	Dose	Times/day	Med	Dose	Times/day	Med	Dose	Times/day

PHARMACY: _____

ADDRESS: _____

ALLERGIES: ☐ Latex ☐ Iodine ☐ Food (Specify) _____ ☐ Drugs (Specify) _____ Reaction: _____

VITAL SIGNS: 1. Height _____ .ft. _____ in. 2. Weight: _____ lbs.

SOCIAL HISTORY: *(Please Circle)* Single / Married Children Yes / No

Habits: Alcohol consumption: _____ Tobacco: _____ Street drugs: _____

PERTINENT FAMILY HISTORY:

Parents/siblings/children ages and medical conditions. (If deceased, age and cause of death)

_____

_____

_____

_____