BRISTOL ORTHOPAEDICS

Michael E. Cucka, M.D. ☐ Scott W. Organ, M.D. ☐

Patient Name _____ Date of Birth _____ Date _____

MEDICAL HISTORY

Patient Personal History

Ulcers	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Weight	Gain _____	
Cancer	☐ Yes	☐ No					Loss _____	

If YES, where? _____

List Allergies/Reactions (if known): ☐ None	Medications	Surgeries/Dates/Hospital

Patient Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Use of tobacco: ☐ Never ☐ Previously, but quit on: _____ ☐ Current, packs/day _____

Recreational drugs: ☐ Never ☐ Type/frequency: _____

Excessive exposure at home or work to:

☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

Family Medical History

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____

COMPLETE NEXT SIDE

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Date of Visit_____ Date of Birth_____ **Primary Care Physician** _____

Name: _____ Age:___ Sex:___ Ht:___ft.___in. Wt:_____ Referred by: _____

HISTORY OF PRESENT ILLNESS

Is this injury **motor vehicle / work / liability / sports related / none**? (Circle One) Date of injury _____

Reason for today's visit: _____

_____

_____

Please describe how your injury/episode happened:

_____ **SIGNATURE**_____

_____

WHEN: _____

_____

WHERE: _____

Date symptoms began: _____ Area of body involved: _____

Were x-rays taken of this body part? □Yes □No If yes, **when** and **where**? _____

Quality of pain (please circle) dull stabbing throbbing burning Level of pain: 1=low 10=high

Are there associated signs and symptoms (please circle) swelling numbness weakness

Does your pain wake you from sleep? _____

What makes your pain worse? _____

What makes your pain better? _____

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Review of Systems:

Gen:	NEG	POS_____	**Endo:**	NEG	POS_____
Eyes:	NEG	POS_____	**Muscl:**	NEG	POS_____
ENT:	NEG	POS_____	**Skin:**	NEG	POS_____
Resp:	NEG	POS_____	**Heme:**	NEG	POS_____
Card:	NEG	POS_____	**Neuro:**	NEG	POS_____
GI:	NEG	POS_____	**Psych:**	NEG	POS_____
GU:	NEG	POS_____	**Mem:**	NEG	POS_____
GYN:	NEG	POS_____			

Exam: **Areas: 1 Head/neck 2 Spine/rib/pelvis 3 LUE 4 RUE 5 LLE 6 RLE**

Musculoskeletal	**Neuro/Psych**	**Constitutional/Skin**	**CV/Lymphatics**
Gait OR station	Coordination	General Appearance	Peripheral vascular system
Inspection, percussion, &/or palpation	Deep tendon flexes, &/or nerve stretch	Skin inspection &/or palpate	Lymph nodes
ROM	Sensation		
Stability	Orientation – time/place/person		
Muscle strength & tone	Mood		

Doctor's Notes: