Vermont Orthopaedic Clinic

Thomas W. Huebner Medical Office Building

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Rutland, VT 05701

P (802)775-2937

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Name: _____ Date of Birth: _____

Referring Provider: _____ ☐ Right handed ☐ Left handed

Age: _____ Sex: M / F / O

Tell us about your symptoms:

Date of Injury: _____ ☐ MVA ☐ Work related ☐ Not an Injury

What are your Symptoms? _____

Describe your Injury: _____

Which of the following describes you currently? (Please check one)

☐ Working How long have you been at that job? _____

Does your job require lifting, standing, sitting? _____

☐ Not working Why? _____ ☐ Homemaker, retired or unemployed

Employer at time of Injury? _____Is there legal action pending on problem? ☐ Yes ☐ No

Who treated you first for this problem? Dr._____

What treatment did you have then? _____

What do you hope you can accomplish today?

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS Do you have? (Answer yes or no for each)

☐ I have none of the below symptoms.

☐ My primary care physician/provider is aware of my symptoms. **(Please note that if your Primary Care Provider is not aware of the above symptoms, you should notify him/her.)**

Fever/Chills	☐ **Yes** ☐ **No**	Cough	☐ **Yes** ☐ **No**	Balance issues	☐ **Yes** ☐ **No**
Night sweats	☐ **Yes** ☐ **No**	Nausea	☐ **Yes** ☐ **No**	Leg numbness/tingling	☐ **Yes** ☐ **No**
Weight loss	☐ **Yes** ☐ **No**	Vomiting	☐ **Yes** ☐ **No**	Arm numbness/tingling	☐ **Yes** ☐ **No**
Headaches	☐ **Yes** ☐ **No**	Abdominal pain	☐ **Yes** ☐ **No**	Excessive thirst	☐ **Yes** ☐ **No**
Dizziness	☐ **Yes** ☐ **No**	Heartburn/Reflux	☐ **Yes** ☐ **No**	Anxiety	☐ **Yes** ☐ **No**
Chest pain	☐ **Yes** ☐ **No**	Urinary changes	☐ **Yes** ☐ **No**	Depression	☐ **Yes** ☐ **No**
Shortness of breath	☐ **Yes** ☐ **No**	Rash	☐ **Yes** ☐ **No**	Excessive bruising	☐ **Yes** ☐ **No**
Thoughts of Suicide	☐ **Yes** ☐ **No**				

Social History

Occupation: _____ Employer: _____

If retired, list previous occupation: _____

Disabled: _____Reason:_____

Marital Status: (please circle one) Single Married Divorced Widowed

Highest grade of school completed: (please circle one) Elementary High School College Post Graduate

Alcohol Use: ☐ None

Amount _____per ☐ Day ☐ Week ☐ Month ☐ Year

Tobacco Use: ☐ Current Everyday ☐ Current Some Days ☐ Never ☐ Former

_____ Packs/Cigars/Chewing a day for _____ years. Quit smoking _____years ago.

Illicit Drug Use: ☐ None Type: _____

Frequency _____days/weeks/months Date of Last Use _____

Caffeine Use: ☐ None

(Please Circle all that Apply) Coffee Tea Soda Energy Drinks _____Cups per day

Regular Exercise: ☐ Yes ☐ No **Explain:** _____

Family History (Please check all that apply)

Disease/Condition					
Alcoholism/Drug Abuse		Depression		Liver Disease	
Alzheimer's/Dementia		Diabetes		Mental Illness	
Anxiety		Fibromyalgia		Obesity	
Arthritis		Hypertension		Stroke	
Cancer		Kidney Disease/Infections			

Past Medical History: Please circle if you have/had any of the following:

Anemia	Fibromyalgia	High Blood Pressure	Prostate Issues
Anxiety	Fracture/Broken Bones	High Cholesterol	Rheumatoid Arthritis
Asthma	Glaucoma	Irritable Bowel Syndrome	Seizures
Bronchitis	Heartburn/GERD/Reflux	Kidney Problems	Spinal Cord Injury
Currently Breast Feeding	Heart Attack/Failure	Multiple Sclerosis	Stomach Ulcers
Currently Pregnant	Heart Problems	Osteoarthritis	Stroke
Depression	Heart Stents	Pacemaker	Substance Abuse
Diabetes	Heart Surgery	Parkinson's Disease	Thyroid Disease
Emphysema			

Cancer: Type_____ Other_____

MEDICATION LIST (Include prescriptions, herbals and over the counter medications)

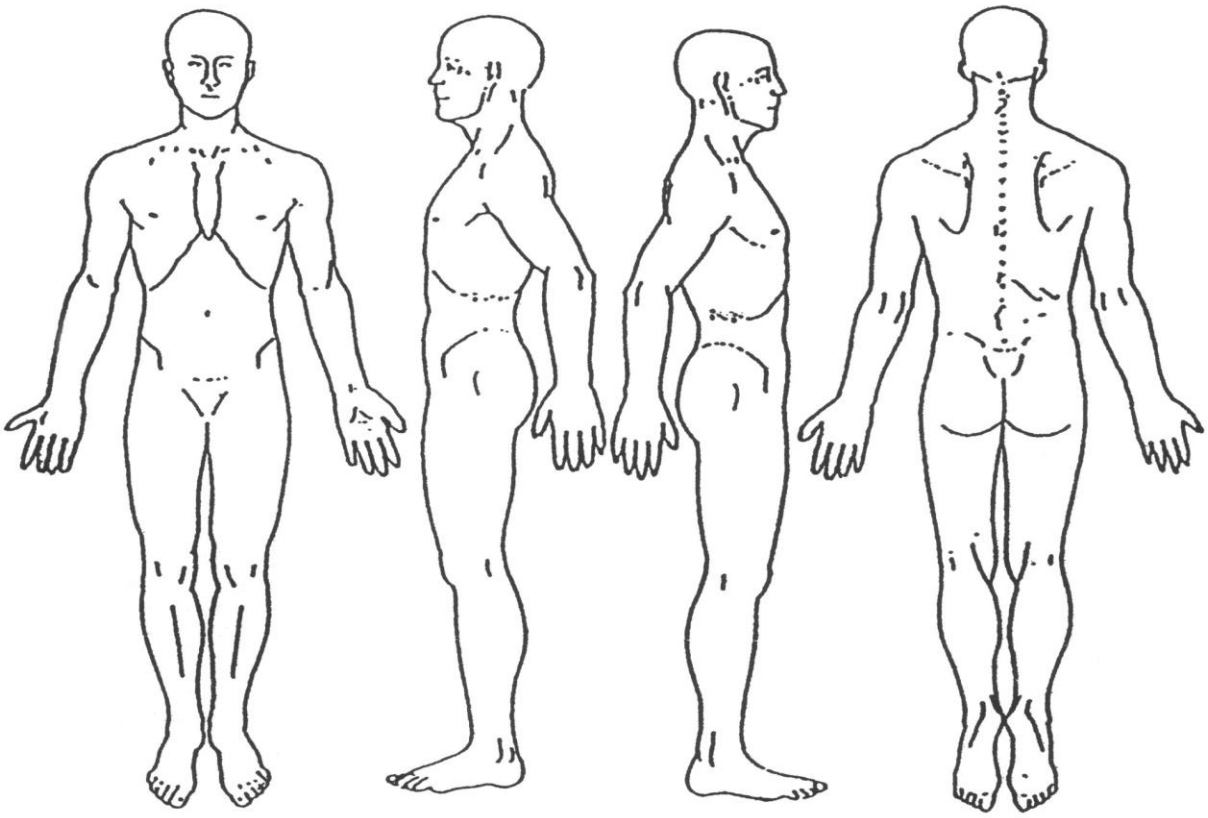
Medication	**Strength (dosage)**	**Times per Day**

Allergies ☐ Yes (See Below) ☐ No Known Drug Allergies

Medication You are Allergic To	Reaction

PAIN DIAGRAM: Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel. Next if the pain starts in a particular area, mark that area with#1 and circle it. If there is more than one area, mark them as #2, #3, etc... If your pain radiates, draw an arrow from where it starts to where it stops.

Please extend the arrow as far as the pain travels (i.e. to the arm, hip, knee, etc.). Describe the radiation.
Mark the areas on your body where you feel your pain. Include all affected areas. Use the appropriate symbol indicated below:
Ache >>>> Numbness ==== Pins & Needles oooo Burning xxxx Stabbing //// Throbbing // // //



Rate your pain:

(no Pain) 0 1 2 3 4 5 6 7 8 9 10 (worst Pain)

Worst Day #_____ Best Day #_____ Today #_____

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____ Time: _____

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