UNIVERSITY ORTHOPEDICS
Healers. Innovators. Teachers.

Dr. Brett Owens, Sports Medicine

INITIAL VISIT/NEW PATIENT

Please complete this form accurately as it will become part of your medical record with our office. Thank you.

YOUR NAME: _____ **AGE:** _____ **BIRTHDATE**: _____

YOUR PRIMARY CARE DOCTOR: _____

WERE YOU REFERRED TO DR. OWENS BY ANOTHER PHYSICIAN OR THERAPIST? _____

DO YOU HAVE ANY DRUG ALLERGIES?: _____ **REACTIONS:** _____

_____ _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING (CIRCLE):

LATEX ALLERGY **MALIGNANT HYPERTHERMIA** **BLEEDING DISORDER** **BLOOD CLOT** **SLEEP APNEA**

Current Height _____ **Current Weight** _____

MEDICATIONS	**DOSE**	**FREQUENCY**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently have problems with or have you sought treatment for (Please circle all that apply)

Migraines	Blood Pressure	Cholesterol	Visual Problems	Hepatitis
Hearing Loss	Thyroid	Asthma	Emphysema	Pneumonia
Chest Pain/Angina	Heart Attack/Stent	Irregular Heartbeat	Ulcers	AIDS
Reflux/GERD	Cardiac Bypass Surgery	Prostate	Urinary Infection	Kidney
Circulation	Diabetes	Substance Abuse	Arthritis/Joints/Gout	Cancer
Angioplasty	Psychological/Depression	Stroke	Eyes, Ears, Nose, Throat	Seizures
Tonsils	Blood Clots/DVT/PE	Nerve Injury	Gallbladder	Bowel/Bladder
Serious Infection	Gout	Other: _____		

PRIOR SURGERY (Please circle all that apply)

Tonsils	Eye	Ear/Nose/Throat	Thyroid	Cosmetic
Heart Bypass	Gallbladder	Appendix	Prostate	Bowel
Breast Biopsy	Mastectomy	Vascular	Lung	Stomach

Previous Orthopedic Surgery_____

Explain: _____

PLEASE CONTINUE ONTO NEXT PAGE

Marital Status? _____

Occupation: _____

Do you exercise? **YES / NO** How often? _____

Do you currently smoke? **YES / NO** _____Packs per day for_____years.

Did you previously smoke but have QUIT? **YES / NO**

Do you drink alcohol? **YES / NO** _____ Drinks a day/week/month (circle one)

Do you use drugs? **YES / NO** If so which one(s)_____

PRIOR ORTHOPEDIC CARE:

Type/Body Part	Dates	Doctor	Hospital
_____	_____	_____	_____
_____	_____	_____	_____

TODAY'S VISIT

Reason for visit: _____

_____

Is this a second opinion? YES / NO Previous surgeon_____

Is there a Workmans Compensation claim for this injury? YES / NO Is there litigation or pending litigation (lawsuit)? YES / NO

Your current problem is the result of (please circle): Sport Injury Work Injury Car Accident Other: _____

Date of injury/onset of symptoms: _____ **Are you getting:** Better Worse About the same?

Describe your pain (Circle all that apply): Sharp – Dull – Burning – Constant – Occasional –

How would you rate your current level of pain? (Please circle)

Mild- 1 2 3 4 5 6 7 8 9 10 **-Severe**

What makes this feel better? Rest – Heat-- Ice – Wrap -- Brace - Cane/Crutches - NSAIDs - Narcotics - Therapy

On a Scale of 1-100, 100 being perfect; how would you rate your area of concern (shoulder, knee, etc) today:

SANE SCORE: (0= worst, 100= perfect) = _____

Does your joint feel (Circle all that apply): Unstable – Swollen – Stiff – Clicking – Popping - Other _____

Have you had prior treatment for this problem? **YES / NO** With who? _____

Have you had any prior imaging on this body part? **YES / NO** Where/When?_____

Other information you think is important:

_____

_____

Patient Signature _____ Date_____

Reviewed_____