ROMANO ORTHOPAEDIC CENTER

Romano Orthopaedic Center
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PATIENT ASSESSMENT

I have brought outside films: ◯ X-ray ◯ MRI ◯ None
Which is your dominant hand? ◯ Right ◯ Left ◯ Ambidextrous

HISTORY OF PRESENT ILLNESS (HPI) (Please tell us the reason for you visit.)

Chief Complaint: (What brings you to the office today?)

Which side of your body is affected? ◯ Right ◯ Left

Describe in detail what brings you here?

Approximate date of the onset of the present problem:

What is the intensity of your pain now? (Please circle one.) None 0 1 2 3 4 5 6 7 8 9 10 Severe

How long have you had symptoms/pain (weeks, months, years)?

Does the pain radiate? ◯ Yes ◯ No If yes, where?
(i.e., shoot up or down, or travel)

Were there any previous injuries ◯ Yes ◯ No If yes, explain?
or problems in this area?

Type of pain? (√)	Timing of pain: (√)
Burning	Frequent
Aching	Constant
Stabbing	Sudden
Throbbing	Intermittent
Sharp	At night
Dull	Early morning
Deep	After work/exercise
Other:	Other:

What makes the pain worse? (√)		What relieves your pain? (√)
Bending/squatting	Rising from chair	Nothing
Running	Prolonged weight bearing	Rest, ice, elevation
Cutting	Laying on side	Prescription meds
Twisting	Reaching overhead	Over-the-counter meds
Climbing stairs	Reaching behind back	Steroid injections
Crossing legs	Holding an object	Synvisc injections
Lifting	Pushing/pulling	Therapy
Other:		Other:

Do you have any of the associated symptoms?

Yes	No		Yes	No		Yes	No	
		Headaches			Weakness			Numbness or tingling
		Swelling			Locking			Difficulty reaching overhead
		Fever			Catching			Difficulty gripping
		Chills			Giving way			Dropping objects
		Warmth			Stiffness			Difficulty sleeping
		Redness			Difficulty climbing stairs			Waking up with pain
Other:			Other:			Other:		

Any previous treatments for this problem?		Results of treatment.
None	Medication	Good relief
Physical therapy	Weight loss	Some relief
Home exercise	Bracing	Little relief
Steroid injections	Cane	Intermittent relief
Synvisc injections	Walker	Inconsistent relief
Other:		No relief
		Made worse

Previous tests?	Results of tests.
Xrays	
MRI	
EMG	
Bone density (DEXA)	
Vitamin D testing	
Other:	

OBSTETRICAL HISTORY (For Females only)

Are you currently pregnant? ◯ No ◯ Yes No. of Children: _____ No. of Pregnancies: _____ No. of Children: _____

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MEDICATION HISTORY (*Please list all prescription drugs and all drugs you buy over the counter.*)

Medication	Dose/Strength	When do you take it?	Reason you take the medication.

ALLERGIES ◯ No Allergies

List any allergies you have (i.e. latex, metal, drugs, food or environmental) and what type of allergic reaction you experience.

Medication/Substance	Reaction

YOUR PERSONAL MEDICAL HISTORY (Please tell us a little about your past medical history.)

	Yes	No		Yes	No		Yes	No
Adrenal insufficiency			Glaucoma			Osteomyelitis		
Alzheimer's disease			Gout			Osteopenia		
Anemia			Heart attack (MI)			Osteoporosis		
Anorexia/Bulimia			Heart disease			Paget's disease		
Anxiety			Heart palpitations			Parathyroid disease		
Asthma			Hepatitis A			Parkinson's disease		
Atrial Fibrillation (A-Fib)			Hepatitis B			Pneumonia		
Bladder control problems			Hepatitis C			Psoriasis		
Bladder infections			High blood pressure			Pulmonary embolism		
Bleeding tendency			High cholesterol			Rheumatoid arthritis		
Blood clots (DVT)			HIV			Sciatica		
Bronchitis			Hyperthyroidism			Seizure		
Bone Cancer			Hypothyroidism			Shingles		
Cancer (other)			History of fractures			Sleep apnea		
Type of Cancer: _____			Kidney disease			Sleep disorder		
Celiac disease			Kidney stones			Steroid use		
Coagulation disorder			Liver disease			Stomach ulcers		
COPD			Lung disease			Stroke		
Dementia			Lupus erythematosus			Thyroid disease		
Depression			Lyme disease			Tuberculosis		
Diabetes, Type 1			Malignant hyperthermia			Varicose veins		
Diabetes, Type 2			Migraine headaches			Vitamin D deficiency		
Diverticulitis			Multiple sclerosis			Other:		
Emphysema			Osteoarthritis					
Esophageal reflux			Early menopause (< 45 yrs old)					
Fibromyalgia			Age of menopause:					

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SURGERIES

Have you ever been hospitalized? (also include any past surgeries)	If so what year and what was it for?

YOUR FAMILY MEDICAL HISTORY (Parents, siblings, grandparents and other relatives.)

	Mother	Father	Siblings	Grandparent	Other		Mother	Father	Siblings	Grandparent	Other		Mother	Father	Siblings	Grandparent	Other
Adrenal Insufficiency						Gout						Osteomyelitis					
Alzheimer's disease						Heart attack (MI)						Osteopenia					
Anemia						Heart palpitations						Osteoporosis					
Anxiety						Hepatitis A						Paget's disease					
Anorexia/Bulimia						Hepatitis B						Parathyroid disease					
Asthma						Hepatitis C						Parkinson's disease					
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Diabetes, type 1						Lyme disease						Thyroid disease					
Diabetes, type 2						Malignant hyperthermia						Tuberculosis					
Diverticulitis						Migraine headaches						Varicose veins					
Emphysema						Multiple sclerosis						Other:					
Esophageal reflux						Early menopause											
Fibromyalgia						(before age of 45)											
Glaucoma																	

SOCIAL HISTORY

Smoking ◯ Never smoked ◯ Currently Smoke ◯ Formerly Smoked

How many packs/day do or did you smoke?	
What year did you start smoking?	
What year did you quit smoking?	

Do you have exposure to passive smoke?	◯ Yes ◯ No
Have you been advised to quit smoking?	◯ Yes ◯ No

Alcohol Do you drink alcohol? ◯ Yes ◯ No

How many drinks do you have on a typical day? ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7-9 ◯ 10 or more

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Have you ever felt you should **cut down** on your drinking? ◯ Yes ◯ No	Have you ever felt bad or **guilty** about your drinking? ◯ Yes ◯ No
Have people **annoyed** you by criticizing your drinking? ◯ Yes ◯ No	**Eye opener**: Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover. ◯ Yes ◯ No

Drugs

Are you taking any unprescribed drugs, including recreational drugs? ◯ Yes ◯ No

If yes, please specify:

Behavioral

Have you experienced and domestic abuse?	◯ Yes ◯ No
Do you use a seatbelt regularly?	◯ Yes ◯ No

Do you have a risk of developing AIDS?	◯ Yes ◯ No
Does your religion affect your medical care?	◯ Yes ◯ No

Residence

Please indicate your place of residence:

◯ Home with stairs ◯ Home without stairs ◯ Assisted living ◯ Nursing home ◯ Homeless

Bone Health

Do you get calcium in your diet daily?	◯ Yes ◯ No
Do you take vitamin D supplementation?	◯ Yes ◯ No
Do you exercise regularly?	◯ Yes ◯ No

Date of last Bone Density (DEXA) exam? ◯ Yes ◯ No
Results: ◯ Normal ◯ Osteopenic ◯ Osteoporosis
What is your T-score?

REVIEW OF SYSTEMS (ROS)

Please indicate which, if any, of the following problems you have by checking Yes or No.

	Yes	No		Yes	No		Yes	No
General Health			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good general health			Hearing loss or ringing			Wear glasses/contact		
Recent weight change			Sinus problems			Blurred/double vision		
Night sweats, fevers			Nose bleeds			Eye disease or injury		
Fatigue			Eye disease or injury					
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest pain			Shortness of breath			Nausea/vomiting		
Palpitations			Cough			Abdominal pain		
Heart trouble			Coughing up blood			Rectal bleeding		
Swelling hands/feet						Bowel problems		
Musculoskeletal			**Neurological**			**Integumentary (Skin/Breast)**		
Muscle pain or cramps			Frequent headaches			Change in hair or nails		
Stiffness/swelling joints			Paralysis or tremors			Rashes or itching		
Trouble walking			Numbness/tingling			Breast lump		
						Breast pain or discharge		
Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination			Bruising easily			Food allergies		
Hormone problem			Slow to heal			Aspirin allergies		
			Enlarged glands			Antibiotic allergies		
Genitourinary-Male Only			**Genitourinary-Female Only**			**Psychiatric**		
Blood in urine			Blood in urine			Insomnia		
Kidney stones			Kidney stones			Confusion/memory loss		
Sexual problems			Sexual problems			Anxiety		
Testicle pain			Menstrual problems			Substance abuse		