

North Texas Orthopaedic Specialists

A Baylor-HealthTexas Affiliate

J. Scott Quinby, MD

1. Name: _____ Today's date: ____/____/____

2. How were you referred to our office? Physician _____
 Patient _____ Insurance website
 Other _____

3. Your age: _____ Approximate weight: _____ Approximate height: _____

4. Hand dominance (Which hand do you use most often?): RIGHT LEFT

5. Chief complaint(s) (What brings you in today?): _____

6. History of current complaint (Tell me more about your problem.):

Duration (How long have you had your problem?):
_____ days *or* _____ weeks *or* _____ months *or* _____ years

Location (Where is the problem located?):
 RIGHT LEFT Shoulder Elbow Hand Neck
 Hip Knee Ankle Back

Complaint (Describe your problem. Please check all that apply.):
 Pain Swelling Catching Instability Other: _____

Frequency (How often do you have your problem?):
 Constant Intermittent Activities only At rest Other: _____

Timing (When does this problem occur?):
 Daytime Nighttime Work Sports "Activities of Daily Life"
 Morning End of the day Other: _____

Modifying factors (What makes your symptoms better?):
 Ice Rest Positional changes Activity modification (avoidance)
 Other: _____

Previous treatments (How has your problem been treated in the past?):
 Advil®/Motrin®/Aleve®/Tylenol® Vicodin® (hydrocodone)/Darvocet®
 Physical Therapy (Location: _____ Duration: _____)
 Injections (last received: _____) Chiropractor
 Other: _____

7. Past Medical History

Check here if none

<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Other:

<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Other:

<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Blood clots
<input type="checkbox"/> HIV
<input type="checkbox"/> Other:

8. Past Surgical History

Check here if none

Check here if separate sheet attached

Surgery	Year

Surgery	Year

9. Current Medications

Check here if none

Check here if separate sheet attached

1.		3.	
2.		4.	

10. ALLERGIES

Check here if none

<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine
<input type="checkbox"/> Other:

<input type="checkbox"/> Cephalosporins
<input type="checkbox"/> Iodine (contrast)
<input type="checkbox"/> Other:

<input type="checkbox"/> Latex
<input type="checkbox"/> Iodine (topical)
<input type="checkbox"/> Other:

11. Family History

Check here if none

<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Rheumatoid Arthritis

<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Stroke
<input type="checkbox"/> Osteoarthritis

<input type="checkbox"/> Lung Condition
<input type="checkbox"/> Cancer
<input type="checkbox"/> Other:

12. Social History

Occupation:		Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Significant other	
Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Packs per day: <input type="checkbox"/> <1; <input type="checkbox"/> 1; <input type="checkbox"/> >1; Number of years: _____	
Do you drink alcohol?	<input type="checkbox"/> No, never (or rarely) <input type="checkbox"/> Yes, <input type="checkbox"/> Daily; <input type="checkbox"/> 1 to 3 times per week; <input type="checkbox"/> 1 to 3 times per month	

13. Review of Systems (please check *any* that apply)

Check here if nothing to report

General	Psychiatric	Neurological	Endocrine
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Depression	<input type="checkbox"/> Headache	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Stroke	<input type="checkbox"/> Pituitary Disease
Respiratory	Heart	Genitourinary	Blood
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> ↑ Blood pressure	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Short of breath	<input type="checkbox"/> Irregular Pulse	<input type="checkbox"/> Prostate cancer	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Urinary infections	<input type="checkbox"/> Sick cell
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Swelling in legs	<input type="checkbox"/> Kidney stones	
Bones/joints	GI	Allergy/Immune	Skin
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Nausea	<input type="checkbox"/> Food allergies	<input type="checkbox"/> Rashes
<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Immune disorders	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Gout	<input type="checkbox"/> Abdomen Pain		