Sheena Black, MD

Orthopedic Surgeon

Sports Medicine Specialist

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NAME:	DOB: / / AGE:	Height: ft in Weight: lbs

Primary Care Physician: _____

Who referred you?/ How did you find us?: _____

Occupation: _____ **RIGHT-HANDED/ LEFT-HANDED/ BOTH** (circle one)

CHIEF COMPLAINT:

What is the reason for your visit? **Right / Left / Bilateral** _____

_____

_____

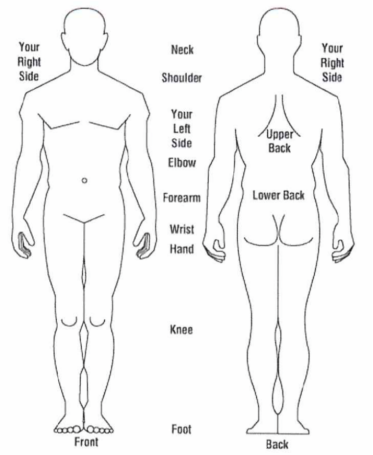
Please Describe Your Symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Other:			

Current Pain Level: ((no pain) 0 – 10 (highest))

0	1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



When did this condition start?_____

Please explain how this condition started: _____

_____

Does anything make the pain better? _____

Does anything make the pain worse? _____

Have you had to modify your activities? Yes / No

Are you still able to play sports/ exercise? Yes / No

Current exercise activities: _____

_____

Have you had or tried any of the following (please select and describe)?

Yes?	TYPE	Effective?	Additional Comments
☐	X-Ray		
☐	MRI / CT		
☐	Anti-inflammatory Medications	Yes No	
☐	Injections ☐ steroid ☐ visco/ gel	Yes No	
☐	Physical Therapy	Yes No	
☐	Acupuncture/ Chiropractic	Yes No	
	Other:	Yes No	

Please list the physician(s) that have treated you previously for this problem:

Physician: _____ Specialty: _____

ALLERGIES	REACTION
☐ **NO ALLERGIES**	

Are you currently on any blood thinners? ☐ NO ☐ YES, which _____

Can you take anti-inflammatory medications (ex. Ibuprofen/Advil) ☐ YES ☐ NO, why not?_____

Pertinent Orthopedic Surgical History	Date of Surgery
1.	
2.	
3.	
4.	

Have you ever had any problems with Anesthesia? Yes / No _____

Have you ever had any complications from prior surgery? Yes / No _____

Have you ever had a **Deep Vein Thrombosis (DVT) (Blood Clot)**? Yes / No

Have you ever had a **Pulmonary Embolism (PE)**? Yes / No

Has anyone in your family ever had a **DVT** or **PE**? Yes / No

Do you think you may be pregnant? N/A / Yes / No

Do you have a history of **Obstructive Sleep Apnea** Yes / No

Do you use a CPAP Machine? Yes / No

MANDATORY: PROVIDE YOUR PHARMACY INFORMATION

Pharmacy Name & Address: _____

Pharmacy Phone Number: _____

STOP HERE IF YOU PERFORMED E-CHECK IN

Personal Medical History (select all that apply)				
Diabetes	High Blood Pressure	Heart Problems	Lupus	Sleep Apnea
High Cholesterol	COPD	Heart Attack	Lyme Disease	Stroke
Atrial Fibrillation	Cancer	Hepatitis	Osteoporosis	Thyroid Disease
Anemia	Congestive Heart Failure (CHF)	HIV/ AIDS	Peripheral Vascular Disease	Stomach Problems (Ulcers, Reflux)
Arthritis	Emphysema	Irregular Heartbeat	Pneumonia	Urinary Problems
Asthma	Fibromyalgia	Kidney Disease	Rheumatoid Arthritis	Other:
Bleeding Disorder	Gout	Muscle Diseases	Depression/ Anxiety	

MEDICATIONS	Route (oral, injection, etc.)	Dose	Frequency
☐ **NO MEDICATIONS**			
1.			
2.			
3.			
4.			

SOCIAL HISTORY

1. Are you a tobacco user? Yes / No How Much/ Often?_____
2. Do you consume alcohol? Yes / No How Much/ Often?_____
3. Do you use recreational drugs? Yes / No How Much/ Often?_____
4. Do you have a history of falls? Yes / No How Often? _____

FAMILY HISTORY

Are there any illnesses that run in the family?			
Anesthesia Problems	Yes	No	Relation: _____
Autoimmune Disease	Yes	No	Relation: _____
Arthritis	Yes	No	Relation: _____
Cancer	Yes	No	Relation: _____
Diabetes	Yes	No	Relation: _____
Heart Disease	Yes	No	Relation: _____
High Blood Pressure	Yes	No	Relation: _____
Osteoporosis	Yes	No	Relation: _____
Pulmonary Disease	Yes	No	Relation: _____
Stroke	Yes	No	Relation: _____
Other: _____			Relation: _____

REVIEW OF SYSTEMS: Are you **currently** experiencing any of the below symptoms (select all that apply):

Constitutional	EYES	Gastrointestinal	Endocrinology
Fever	Blurred Vision	Heartburn	Easy bruising
Chills	Double Vision	Nausea	Easy bleeding
Weight Loss	Light Sensitivity	Vomiting	Allergies
Fatigue	Eye Pain	Abdominal Pain	Increased thirst
Night sweats	Watering	Diarrhea	
Weakness	Redness	Constipation	
		Blood in stool	
None	None	None	None

Skin	Cardiovascular	Genitourinary	Neurological
Rash	Chest Pain	Painful Urination	Dizziness
Itching	Palpitations	Difficult urination	Headaches
	Fainting	Frequent urination	Tingling
	Leg Pain/ Cramping	Blood in urine	Tremor
	Leg Swelling	Flank Pain	Sensory Change
	Night shortness of breath		Speech Change
			Seizures
None	None	None	None

Head/Ear/Nose/Throat	Respiratory	Musculoskeletal	Psychiatric
Hearing Loss	Cough	Muscle Pain	Depression
Ringing in ears	Blood in sputum	Neck Pain	Suicidal Ideas
Ear Pain	Sputum/ Mucus	Back Pain	Substance Abuse
Nosebleeds	Shortness of Breath	Joint Pain	Hallucinations
Congestion	Wheezing	Falls	Nervous/ Anxious
Sinus Pain			Insomnia
Sore Throat			Memory Loss
None	None	None	None