Orthopaedic Specialists of Charleston
ROPER ST. FRANCIS PHYSICIANS

CHART#:___________

NEW PATIENT INFORMATION **DATE**: ______________

Name: ____ **DOB:** ______________ **Sex:** ***M*** ***F***

Race: _________________**Age**: ___________ **Family MD:** ___________________________________

Involved body part: _______________________ **Referring MD:** ______________________________

Date of injury / onset: _________________________ **Work related:** ***YES*** ***NO***

Last full-time work date: ___________ **Do you need a form to return to work/school:** ***YES*** ***NO***

How injury occurred? : ____

Where injury occurred? : ____

Dominant Hand? *(circle one)*: ***LEFT-HANDED*** ***RIGHT-HANDED***

CHIEF COMPLAINT / HPI: *(the reason for today's visit):*

Location (*Example bottom of foot, left hand, etc*):____

Quality (*Example: throbbing, numb, etc*): ____

Severity (*Example: intolerable, dull, sharp, etc*):____

Duration (*Example: all day, few minutes, all night, etc*):____

Timing *(Example: upon rising, at end of day, etc):*____

Context *(Example: while typing, after exercising, etc):*____

Modifying Factors *(Example: what improves or worsens symptoms, etc):*_____________________________

Associated Signs & Symptoms *(Example: tingling, stiffness, etc):* _________________________________

KNOWN SIGNIFICANT MEDICAL DIAGNOSES AND CONDITIONS:

Height: ___________________ Weight: ______________________

Medical Illnesses: (*Please check below all that apply*)

___ Heart Problems
___ Cerebral Palsy
___ High Blood Pressure
___ Low Blood Pressure
___ Allergies/ Hay Fever
___ Kidney Problems
___ Circulatory Problems
___ Ulcer
___ Asthma
___ Hepatitis
___ Diabetes
___ Gout
___ Cancer
___ Anemia
___ Depression
___ Arthritis
___ Osteoporosis
___ Severe Anxiety
___ Shortness of Breath
___ Chronic Fatigue
___ Skin Disorders
___ Hyperthyroidism
___ Hypothyroidism
___ Fibromyalgia
___ Epilepsy
___ Malignancies
___ High Cholesterol

Other health complications not listed above: ____

PAST MEDICAL HISTORY:

Known significant medical operative and invasive procedures *(type of surgery and date)***:**

Family Medical History *(list family illnesses)*:

SOCIAL HISTORY:

Do you work outside the home? *YES* *NO* If yes, occupation? ____________________________________

What physical activities do you do on a regular basis*? :* ____

Do you smoke? *YES* *NO* If yes, how much and how long? _______________________________________

Do you consume alcohol? *YES* *NO* If yes, how much and how long? ______________________________

ADVERSE AND ALLERGIC DRUG REACTIONS *(list all)*:

MEDICATIONS CURRENTLY TAKING (*list all*):

OTHER: Are there other questions or concerns that you have for your Doctor/ provider today? If so, please list them below:

Are you a resident of a skilled nursing facility? *YES* *NO*

If yes, name of facility? ____

Address ____

____

Effective Dates From: _____________________________ *TO:* _______________________________________

____ ____

PATIENT / GUARDIAN SIGNATURE **DATE**