Webster ORTHO NOW
URGENT CARE FOR BREAKS, ACHES AND SPRAINS

HISTORY OF PROBLEM

Patient Name: _____ Date: _____

What part of the body are you being seen for? _____

First Symptom or Date of Injury: _____

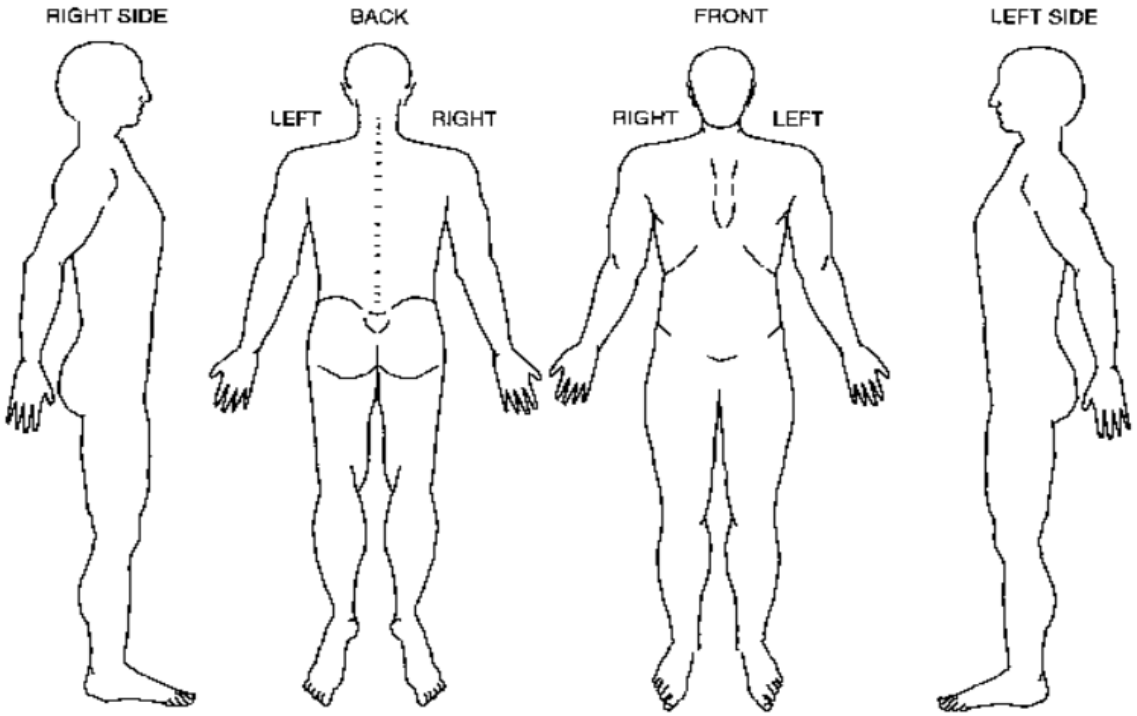
If injury, how did it occur? _____

Pain Level (circle): **0 None** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10 Worst**

Describe Pain (please check (x) all that apply):

☐Aching ☐Bleeding ☐Burning ☐Dull ☐Heaviness ☐Joint Locking ☐Loss of Motion
☐Numbness ☐Radiating ☐Sharp ☐Stinging ☐Swelling ☐Tingling ☐ Weakness

Please mark with an "X" where you are experiencing pain:



Was an automobile involved in this injury? ☐ YES ☐ NO

Date of accident: _____ Name of Attorney:_____ Phone: _____

Was this injury at work? ☐ YES ☐ NO

☐ Is this a Workers Comp injury? ☐ Are you filing under private insurance?

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Health Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Care Doctor: _____ Referring Doctor: _____

DRUG ALLERGIES: (Please indicate by checking the boxes below)
☐NO KNOWN DRUG ALLERIGES

☐Novocain, etc. ☐Penicillin ☐Keflex ☐Erythromycin ☐Other Antibiotic: _____

☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Morphine ☐Percocet ☐OxyContin ☐Other Painkillers: _____

☐Latex ☐Egg/Yolks ☐Sulfites ☐Tetracycline ☐Iodine/Shellfish ☐Ibuprofen, etc.

Please specify any others: _____

Please specify type of reaction: _____

MEDICINES: (Please list any medications or supplements that you take regularly, with dose/frequency)
(Print Clearly)

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

SOCIAL HABITS: (It is now a government requirement that we ask you the below information)

Tobacco: Do you smoke tobacco products? _____ Check all that apply: ☐Cigarettes ☐Cigars ☐Chewing Tobacco

How much? _____/day Number of years using: _____ If you've quit, when? _____

Have you had Influenza (Flu) shot this year? ☐YES Date:_____ ☐NO

IF OVER 65 YEARS OLD:

Do you have any Advanced Care Directives? ☐YES ☐NO

If YES, please give the name of your Power of Attorney or Surrogate Agent:_____

FALL RISK ASSESSMENT:

Ambulation (move about/walk): ☐Normal ☐Unsteady ☐Needs Assistance (cane, crutches, etc.) ☐Unable to Walk

Have you fallen in the last 12 months? ☐ YES ☐NO If YES, how many times? _____

Did it result in injury? _____ Explain: _____

PATIENT SIGNATURE:_____ DATE: _____

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REVIEW OF SYSTEMS

Have you experienced any of the following in the last few weeks or months?

Please check the complaint and the detail below. If you have no complaints in this category, please check: ☐ **NONE**

General:
☐ Fever
☐ Chill
☐ Sweats
☐ Fatigue
☐ Difficulty Sleeping
☐ Weight Loss
☐ Weight Gain

Cardiovascular:
☐Chest Pains
☐Fainting
☐Leg Swelling
☐Shortness of Breath
☐Murmur

Respiratory:
☐Cough
☐Cold
☐Wheezing
☐Painful Breathing
☐Tuberculosis

Eyes/Ears/Nose/Throat:
☐Glasses
☐Contacts
☐Double Vision
☐Impaired Hearing
☐Runny Nose
☐Nosebleeds
☐Sneezing
☐Dentures
☐Dizziness

Gastrointestinal:
☐ Nausea
☐Vomiting
☐Constipation
☐Loose Stools
☐Abdominal Pain

Skin:
☐Open Sores
☐Boils
☐Wound Breakdown
☐Tender Spot
☐Rash

Neurological:
☐Weakness
☐Numbness
☐Paralysis
☐Loss of Consciousness
☐Headache
☐Slurred Speech

Genitourinary:
☐Urine Incontinence
☐Urinary Frequency
☐Blood in Urine

Endocrine:
☐Fatigue
☐Hyperactivity
☐Excessive Thirst

Heme/Lymphatic:
☐Bruising
☐Bleeding
☐Lymph Node Swelling

Allergic/Immunologic:
☐Hives
☐Persistent Infections
☐HIV Exposure
☐Past Blood Transfusion

Psychiatric:
☐Depression
☐Anxiety
☐Memory Loss
☐Mood Swings

Musculoskeletal:
☐Back Pain ☐Muscle Weakness

Other:_____

☐Neck Pain ☐Joint Swelling

☐Muscle Cramps ☐ Joint Pain