THE Portland Clinic®
We specialize in you.

PATIENT LABEL

ORTHOPEDIC NEW PROBLEM FORM

Referring doctor: ________________

What problem are you here to have looked at today?

* Please describe what happened or how it started:

* How long has it been going on?

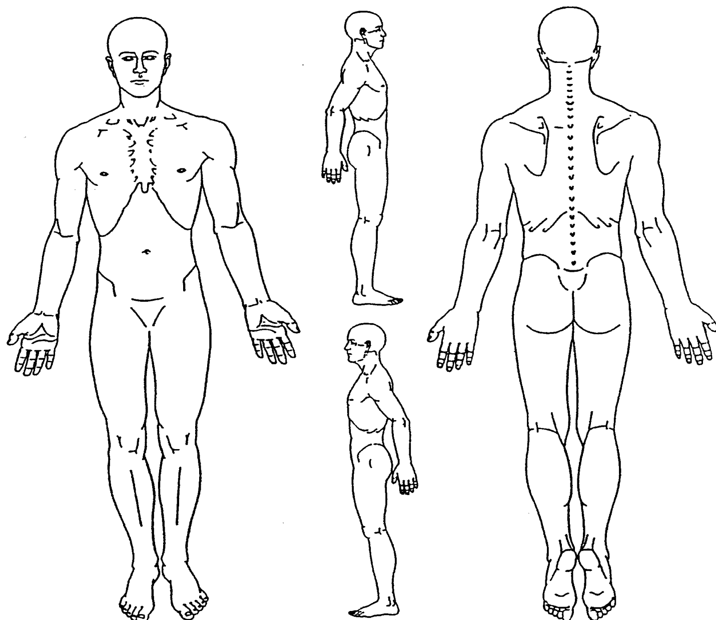
* What makes it better?

* What makes it worse ?

What treatments have you tried so far?

* If you have pain, how severe is it:
No pain 1 2 3 4 5 6 7 8 9 10 severe pain

* Please mark where you feel pain:



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ORTHOPEDIC MEDICAL HISTORY

What kind of work do you do?

What do you do for exercise?

* Do you have a history of any medical problems? (For example high blood pressure):

Medications:

Allergies:

Surgical History (and approximate dates):

Other hospitalizations?

* **FAMILY HISTORY**: diabetes, heart disease, arthritis, bleeding problems, cancer, Other___________________________ NONE

* Do you smoke? ❒ Y ❒ N Have you ever smoked? ❒ Y ❒ N

* **REVIEW OF SYSTEMS: CHECK ANY YOU HAVE, OR CIRCLE "NONE"**

❒ Constitutional: fever, chills, fatigue, unexpected weight gain or loss NONE

❒ CV: Chest pain, high blood pressure, abnormal EKG, Abnormal rhythm, heart attack NONE

❒ Lungs: shortness of breath, asthma, sleep apnea NONE

❒ GI: heartburn, ulcers, nausea, hepatitis NONE

❒ MS: joint pain or swelling, Muscle pain, leg cramps NONE

❒ Skin: poor healing, rash, itching, skin infections NONE

❒ Endocrine: excessive thirst or urination, diabetes NONE

❒ Hematologic: bleeding tendencies such as hemophilia, easy bruising NONE

❒ Neurologic: headaches, fainting, stroke, numbness, tingling NONE

❒ Psychiatric: depression, anxiety NONE

❒ Immune: rheumatoid arthritis, gout NONE

❒ Have you had problems with anesthesia? NONE