SEA VIEW ORTHOPEDICS - NEW INJURY / PROBLEM

NAME: _____ EMAIL ADDRESS: _____

WHO REFERRED YOU TO THIS OFFICE: _____

YOUR INJURY / WHAT HURTS: _____

DATE OF INJURY / HOW LONG HAS IT HURT: _____

VITALS: HEIGHT _____ WEIGHT _____

NEW MEDICAL CONDITION(PLEASE CIRCLE): NO or YES _____

SURGERIES SINCE LAST VISIT: NO or YES _____

NEW/CHANGE IN MEDICATIONS: NO or YES _____

NEW ALLERGY: NO or YES _____

REVIEW OF SYSTEMS:

General: NONE Fevers/Chills Fatigue Weight Loss/Gain Intentional Weight Loss
Dizziness Headaches Loss Of Consciousness

Neurologic: NONE Loss Of Balance Weakness Clumsiness Numbness/Tingling Tremors

Cardiac: NONE Chest Pain Palpitations Fainting Murmurs

Pulmonary: NONE Shortness Of Breath Cough Wheezing Snoring

GI: NONE Nausea/Vomiting Abdominal Pain Diarrhea Bloody/Tarry Stool

GU: NONE Painful/Difficult/Frequent/Bloody Urination Flank Pain Kidney Stones

Heme: NONE Excessive Bruising Easy/Excessive/Prolonged Bleeding

Skin: NONE Rash Itching Redness Skin Changes Masses/Bumps

Eyes: NONE Blurry/Double/Cloudy Vision Eye Pain Contact Lenses/Glasses

ENT: NONE Hearing Loss Ringing In Ears Ear Pain Sore Throat Difficulty Swallowing

Endocrine: NONE Excessive Thirst/Urination Heat/Cold Intolerance

SIGNATURE:_____ DATE: _____