

Name: **Test, Golf**
Chart: **30489**
Date: **11/3/2006**



ALPINE ORTHOPAEDIC SPECIALISTS
HISTORY AND PHYSICAL

Name: Test, Golf Phone: _____ Birth Date: 6-13-1945 Date: _____
BP: _____ Pulse: _____ Height: _____ Weight: _____ Workman's Comp. Injury? Yes No
What orthopedic problem are you being seen for today? _____
Date/Place/When/How Occurred: _____
Occupation: _____ Referred By: Lori Novich-Welter MD
Prior Treatment: Yes No Prior x-rays? Yes No

DRUG ALLERGIES

WORK HISTORY

CURRENT MEDICATIONS

Pharmacy	Dosage

Briefly explain the type of work you do: _____
Does your work involve heavy lifting? Yes No
Standing for long periods of time? Yes No
Sitting for long periods of time? Yes No
What do you do for exercise? _____

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? Yes No Planning Pregnancy? Yes No Are you nursing? Yes No

PAST MEDICAL HISTORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Anesthetic problems _____ | <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Prostate disease _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Digestive disorder/Ulcer _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Blood clots _____ | <input type="checkbox"/> Heart problems _____ | <input type="checkbox"/> Smoke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Alcohol: Type/amount _____ |
| <input type="checkbox"/> Chronic rashes _____ | <input type="checkbox"/> Hypertension (High Blood Pressure) _____ | |

FAMILY MEDICAL HISTORY: Please mark any of the conditions that your mother (M), father (F), brother (B), or sister (S) has or had

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding problems _____ | <input type="checkbox"/> Cancer _____ | |

REVIEW OF SYMPTOMS

Please check if you are currently experiencing any of the following symptoms:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bladder incontinence | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Nausea | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other |

Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____ Reviewed by: _____ Date: _____