HOSPITAL FOR SPECIAL SURGERY

WHERE THE WORLD COMES TO GET BACK IN THE GAME

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PATIENT NAME: _____ AGE _____ TODAY'S VISIT DATE: _____

CHIEF COMPLAINT: _____

IS THIS A NEW PROBLEM? YES NO

HEIGHT _____ WEIGHT _____

PLEASE LIST ANY QUESTION YOU HAVE FOR THE DOCTOR:

LIST CHANGES TO MEDICATIONS AND DOSES: CHANGES NO CHANGES (CIRCLE ONE)

DO YOU HAVE ANY NEW ONGOING MEDICAL PROBLEMS (diabetes, high blood pressure, etc.)?:

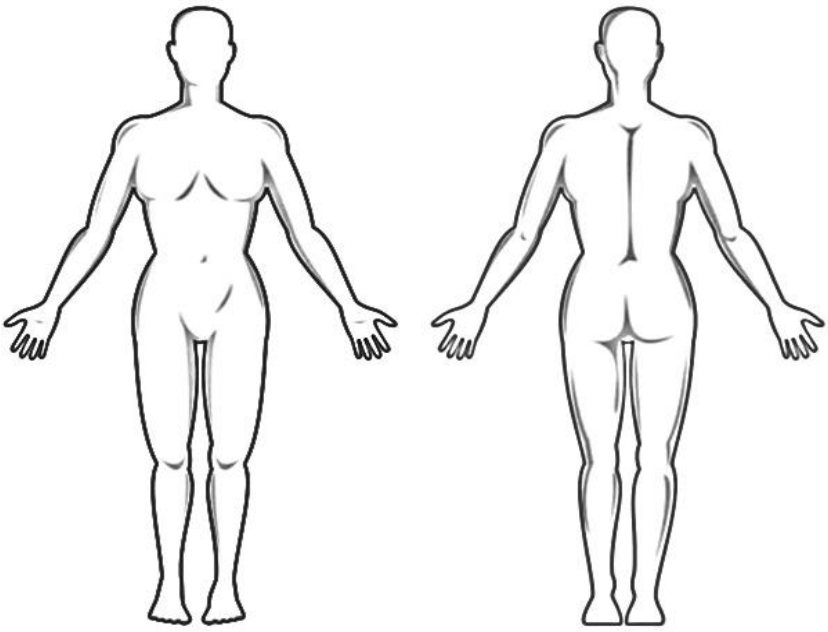
HAVE YOU HAD SURGERY SINCE LAST VISIT, IF YES PLEASE LIST TYPE AND DATES:

DID YOU HAVE ANY PROCEDURES AT YOUR LAST VISIT? YES NO

IF YES, WHAT PERCENTAGE OF PAIN RELIEF DID YOU GET FROM THE PROCEDURE? _____

PAIN DRAWING AND RATING SCALE:

Please mark the drawing by using X's, lines or circles to indicate where you feel pain right now.



KEY

X = Pain
/ = Numbness
O = Tingling

RATE YOUR PAIN

(Please circle the corresponding number)

0 = no pain 10 = extreme pain

1. Right now: 0 1 2 3 4 5 6 7 8 9 10
2. At Best: 0 1 2 3 4 5 6 7 8 9 10
3. At Worst: 0 1 2 3 4 5 6 7 8 9 10
4. Average: 0 1 2 3 4 5 6 7 8 9 10

Describe the pain

_____

What Makes it worse

Sleep Walking Standing Sitting Stairs

Has the problem changed?

Better Worse Same

Please complete both sides of form

PATIENT NAME: _____

REVIEW OF SYSTEMS - Please Check YES or NO on Right for Each

	YES	NO		YES	NO		YES	NO
GENERAL			GASTROINTESTINAL			GENITOURNINARY		
Vomitting	□	□	Abdominal Pain	□	□	Bladder Incontinence	□	□
Chills	□	□	Bowel Habits Change	□	□	Urinary Retention	□	□
Nausea	□	□	Trouble Swallowing	□	□	Urinary Urgency	□	□
Fever	□	□	Heartburn/ Gerd	□	□	Urinating Leakage	□	□
Sleep Difficulty	□	□				CARDIOVASCULAR		
Fatigue	□	□				Chest Pain	□	□
Night Sweats	□	□				Swelling of Extremities	□	□
						Palpitations	□	□
NEUROLOGICAL			MUSCULOSKELETAL			PSYCHIATRIC		
Paralysis	□	□	Decreased Range of	□	□	Depression	□	□
Dizziness	□	□	Motion			Anxiety	□	□
Weakness	□	□	Joint Redness	□	□	Memory Loss	□	□
Loss Of	□	□	Muscle Pain	□	□	Substance Abuse	□	□
Balance			Joint Swelling	□	□	Suicidal Thoughts	□	□
Numbness	□	□	Muscle Cramps	□	□			
Paresthesias	□	□	Muscle Weakness	□	□			
Seizures	□	□	Leg Cramps	□	□			
Difficulty Walking	□	□	Joint Stiffness	□	□			

FALLS RISK ASSESSMENT

Do you have Medicare? Yes_____ No_____ Have you fallen in the last year? No_____

If yes, how many times? □ 1 □ 2 or More

What injuries did you sustain?_____

Have you had any recent Immunizations? List type and Date administered

PATIENT SIGNATURE _____DATE _____

REVIEWING PHYSICIAN SIGNATURE _____DATE _____