MCMC MID-COLUMBIA MEDICAL CENTER | SPORTS MEDICINE AND ORTHOPAEDIC SURGERY

OFFICE USE ONLY	ROOM#
HEIGHT: __________________	BP: _______________
WEIGHT: __________________	PULSE: ____________
☐ OTJ ☐ Attending?	YES NO

NAME: ________________________________ DOB:_____________

TODAYS DATE: ________________________

Date of Injury or Surgery: ___________________________

Body part:________________ Right Left Bilateral

Treatments: Medications you are taking for this condition: ______________________________________

Check all that apply: ☐ Physical Therapy ☐ Home Exercises ☐ Injections ☐ Brace/Cast

Staff Notes: ____

Severity: What is the severity of your pain? (Scale of 0-10) __________________________

Quality: What is the quality of your pain? *Check all that apply* ☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Burning

Context: Since my problem started it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

(*if follow up visit*) How much better do you feel since your last visit? _______%

Timing: The pain is: ☐ Constant ☐ Intermittent Does the pain wake up from your sleep? ☐ Yes ☐ No

Associated Symptoms: Do you have? ☐ Swelling ☐ Bruising ☐ Weakness ☐ Numbness ☐ Tingling

Modify: What makes your symptoms *worse* ?
Circle all that apply

Standing Walking Stairs Squatting Kneeling
Twisting Bending Sittings Exercise Lifting
Overhead Activites Coughing/Sneezing

Other:_________________________________

What makes your symptoms *better* ? Ice Heat Rest Elevation Compression

Symptoms since last office visit: ____

____

____

Work Status: (if applicable)

What is your current job status? ☐ Regular Duty ☐ Light Duty ☐ Retired ☐ Unemployed ☐ Student ☐ Not working due to this condition

When do you expect to return to work? ____

When do you expect to return to full duty? ____

OFFICE USE ONLY
Comments:

MA Initials: _____________

Provider Initials:___________

PATIENT LABEL

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REVIEW of SYSTEMS - Please mark an **"X"** if you are currently experiencing any of the following:

GENERAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Fever
- ☐ Chills
- ☐ Recent weight loss or gain

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Palpitations
- ☐ Pain in legs at rest with elevation (rest pain)
- ☐ Cramping in legs with walking, relieved by rest

NEUROLOGIC
- ☐ Numbness in extremities
- ☐ Tingling in extremities
- ☐ Burning in extremities
- ☐ Radicular pain

RESPIRATORY
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Wheezing
- ☐ Snoring or Sleep apnea

HEMATOLOGY
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Pulmonary Embolus
- ☐ Deep Venous Thrombosis

SKIN
- ☐ Rashes
- ☐ Lumps/Masses
- ☐ Color changes

EYES
- ☐ Blurry vision
- ☐ Double vision

EAR/NOSE/THROAT
- ☐ Sore throat
- ☐ Hearing changes

GASTROINTESTINAL (GI)
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Change in bowel habits

GENITOURINARY (GU)
- ☐ Blood in urine
- ☐ Burning or pain with urination
- ☐ Incontinence
- ☐ Change in frequency or urgency
- ☐ Kidney stones

ENDOCRINE
- ☐ Excessive thirst
- ☐ Heat or cold intolerance

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Sleep disturbances

MUSCULOSKELETAL
- ☐ Swollen joints
- ☐ Warm or red joints
- ☐ Back pain
- ☐ Increased weakness
- ☐ Swelling of extremity

Have there been any changes to your medical history since your last office visit?

☐ No ☐ Yes *(please explain)* ______________________________

____

Signature: ______________________________ Date: ______________

MA Initials: ______________

Provider Initials: ____________

PATIENT LABEL