Phillips Brayford Orthopaedics
48 Tunnel Rd, Suite 203
Pottsville PA 17901
Phone: 570-624-4777 Fax: 570-624-4778

PATIENT INFORMATION

Name:______________________________________ Date of Birth:______________________

Family Physician:____________________________ Referring Physician:___________________

Height:_____________________________ Weight:______________________

Marital Status:___ Single ____ Married ____ Separated ____ Widowed ____ Divorced

Employment Status: ____Employed ____Unemployed ____Disabled ____ Retired ____ Student

Occupation:____________________________________

Sports (currently participating in):____

Hand Dominance: ___LEFT ___RIGHT

Living Arrangements: ___ Private –residence: Lives alone
___ Private – residence: Lives with others
___ Assisted Living Facility
___ Extended Care Facility. Name:________________________________

Is there a Power of Attorney? YES NO

Name:________________________ Relationship:___________________ Phone #:___________

REASON FOR VISIT

Current Problem:____

Referred by:____

How long have you had this problem? (circle one)

Number of :____________ Days Weeks Months Years

Your problem was caused by: (check one)

___Unsure:____

___Auto accident:____

___Other accident:____

___Work Injury:____

___ Sports Injury:____

___Other:____

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PAIN

Where is your pain? .

What is your pain? (rank on a scale 0 to 10, 0 is no pain, 10 is worst pain)
What is your pain right now?____
What is your pain at rest?_____
What is your pain with activity?______
Is your pain: ____ Constant
____ Frequent
____ Occasional
_____ Rare

SYMPTOMS

Please check any that apply:
_____ Back Pain
_____ Joint Pain/Stiffness
_____ Joint Swelling
_____ Numbness/Tingling
_____ Difficulty/Standing
_____ Difficult with Activities of Daily Living
_____ Fever
_____ Other:_________________________________

TREATMENT TO DATE

Have you had any steroid injections? YES NO Date of injections:_____________________

Have you been to Physical Therapy? YES NO

If yes how long?____

Any other treatment?____

Have you had any of the following studies for this problem?

___ X-ray Date:___________________________

___ MRI Date:___________________________

___ CT Scan Date:_________________________

Do you use an assistive device? ___Cane ___Crutches ___Walker ___Wheelchair

___Brace Type:______________________

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ALLERGIES

_____ No Known Allergies

List all your allergies (including food and environmental)

1. ______________________ Reaction:______________________
2. ______________________ Reaction:______________________
3. ______________________ Reaction:______________________
4. ______________________ Reaction:______________________
5. ______________________ Reaction:______________________

MEDICATIONS

_____ I do not take any over-the-counter medications.

_____ I do not take any prescription medication.

List all medications including over-the-counter medications, prescriptions, and vitamins

1. ______________________ Start Date:________ Dose:______________
2. ______________________ Start Date:________ Dose:______________
3. ______________________ Start Date:________ Dose:______________
4. ______________________ Start Date:________ Dose:______________
5. ______________________ Start Date:________ Dose:______________
6. ______________________ Start Date:________ Dose:______________
7. ______________________ Start Date:________ Dose:______________
8. ______________________ Start Date:________ Dose:______________
9. ______________________ Start Date:________ Dose:______________

TOBACCO

___ None ___Former Smoker Date of last use:________ Years of use:______

___Cigarettes ___Cigars ___Smokeless Tobacco How many Packs/Tins per day:______

ALCOHOL

___None ___Quit, Date of last use:_________

___Yes, Type:______________ Amount:______________________

ILLICIT DRUG

___None ___ Quit, Date of last use:_________

___Yes, Type:______________________ Amount:______________________

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PAST MEDICAL HISTORY

___ None
___Arthritis
___Asthma
___Asthma – Exercise Induced
___Asthma – Seasonal
___Blood disorder
___Cancer:________________
___Cataracts
___Congestive Heart Failure
___COPD/Emphysema
___CAD/Heart Disease
___CVD/Stroke ___________
___Depression
___Diabetes – Insulin Dependent
___Diabetes – Noninsulin Dependent
___DVT/Blood Clot __________
___Glaucoma
___Stomach/Bowel _____________
___Gout
___Heart Value Disease
___Heart Attack ________________
___Hepatitis Type:______
___High Blood Pressure
___HIV/AIDS
___High Lipids/Cholesterol
___Hyperthyroid
___Hypothyroid
___Immune Disorder_____________
___Irregular Heart Rate___________
___Kidney Disease______________
___Liver Disease________________
___Muscle/Bone________________
___Pulmonary Embolism
___Prostate/BPH
___Peripheral Vascular Disorder
___Seizures
___Sleep Apnea
___TIA/Mini Stroke
___Tuberculosis
___ Other:__________________

FAMILY HISTORY

___None
___Arthritis
___Asthma
___Blood Clots/DVT/PE
___Blood Disorder
___Cancer:______________________
___COPD/Emphysema
___Diabetes
___Gastrointestinal Disorder
___Heart Disease
___High Blood Pressure
___High Cholesterol
___Immune Disorder
___Kidney Disease
___Liver Disease
___Seizures
___Stroke/CVA/TIA
___Other:______________________________

PAST SURGICAL HISTORY

___Appendectomy____________________
___Angioplasty______________________
___Arthroscopy______________________
___Back/Spine_______________________
___Breast___________________________
___CABG___________________________
___Carotid Endarterectomy____________
___Carpal Tunnel Release_____________
___Cholecystectomy_________________
___C-Section________________________
___Ear______________________________
___Hemorrhoidectomy_______________
___Hernia Repair____________________
___Hip Replacement_________________
___Hysterectomy_____________________
___Knee Replacement________________
___Shoulder Surgery_________________
___T&A ____________________________
___Thyroidectomy___________________
___Wisdom Teeth____________________
___Other:___________________________
___Other:___________________________
___Other:___________________________
___Other:_________________________

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