Colorado Springs Orthopaedic Group

In order to provide you with the highest quality care, it is important for us to have a thorough health history. This information will remain a confidential part of your medical records. Please fill out the following information.

Date: _____ Patient Name: _____ Age: _____

Primary Care MD: _____ Height: _____ Current Weight: _____

Condition	Yes	No	Condition	Yes	No	List all medications you currently take or ask us to copy your list.
Tuberculosis			Fainting/Dizziness/Falls/Imbalance			
Cancer			Pregnancy			
Ulcers			Hernia			
Low/High Blood Pressure			Fracture			
Bowel/Bladder Problems			Alcoholism/Chemical Dependency			
Neck Injury			Blood Clots			
Back Injury			Kidney Disease			
Arthritis/Joint Swelling			Epilepsy/Seizures			
Headaches/Migraines			Do you exercise regularly?			
Hepatitis			Do you smoke?			
Allergies/Asthma			Are you in a relationship where you are being hit, kicked, slapped or otherwise hurt?			
Heart Problems/Pacemaker/Chest Pain						
Diabetes/Neuropathy			Hearing loss/Ringing in ears?			
HIV/AIDS			Cataracts/Glaucoma/Macular Degeneration			
Stroke/Head/Brain Injury						
Shortness of Breath			Do you feel safe at home?			

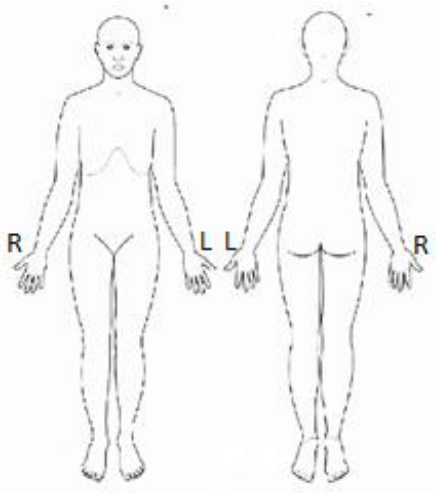
If you checked yes to any of the above please comment:

_____

_____

_____

Number of times you have fallen in the past year: _____



Please mark you area of discomfort or dysfunction on the body diagrams:

When did you first notice pain/problem or have functional limitations due to this condition of injury?

First Episode: _____

Subsequent Episode: _____

Most Recent Episode: _____

How did your Injury/Symptoms Occur? _____

<u>If you have pain please complete the follow pain scale:</u>

(0-No Pain: 10-The Worst Pain You Can Imagine)

0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

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