Windward Orthopaedic Group, Inc.
Linda Rasmussen, MD, Rob Medoff, MD, Brandee Black, MD, Devin Ganesh, MD

Name: _____ **Age:** _____ **Date of birth:** _____

What is the main problem today? _____

Which side hurts? □ Left □ Right □ Both Have you gone to the ER for this? □ No □ Yes

Have you had: □ x-rays □ MRI □ other exams or imaging _____

Is this from a: □ work injury □ automotive injury □ personal injury case □ none of these

When did your pain/symptoms start? _____

What happened? _____

How bad is your pain when resting?

0 1 2 3 4 5 6 7 8 9 10

no pain *severe pain*

How bad is your pain with activities?

0 1 2 3 4 5 6 7 8 9 10

no pain *severe pain*

What have you tried to help the pain/symptoms?

□ rest □ modifying activities □ Tylenol, ibuprofen or Aleve □ ice or heat □ chiropractor

□ physical therapy □ other: _____

Have you ever had surgery in the painful area before? □ No □ Yes

If yes, what surgery? _____

Do you take medications? □ No □ Yes – please list your medicines and the dose below

_____

_____

Do you have any drug allergies? □ No known drug allergies □ Yes – please list below

_____

Medical history, check all that apply to you:

□ Abdominal Aortic Aneurysm	□ Diabetes: □ Type I □ Type II	□ HIV/AIDS
□ Anxiety	□ Depression	□ Irregular heart beat
□ Asthma	□ Epilepsy/Seizures	□ Kidney disease
□ Back problems	□ Fibromyalgia	□ Supplemental oxygen
□ Bleeding disorder	□ Gout	□ Rheumatoid Arthritis (RA)
□ Blood Clots/DVT	□ Heart Attack/MI	□ Sleep Apnea
□ Cancer: type _____	□ Heartburn/GERD	□ Stroke
□ COPD	□ Hepatitis A □ B □ C □	□ Thyroid disease
□ Congestive Heart Failure (CHF)	□ High Blood Pressure	□ Ulcers
□ Coronary Artery Disease (CAD)	□ High Cholesterol	□ Vascular disease/stents

Name: _____ **Age:** _____ **Date of birth:** _____

Who is your primary care doctor or provider? _____

Who referred you here? _____

What do you do for work? _____

Height: ____feet ____in

Weight: _____lbs

Are you right or left handed? □ Right □ Left

Do you smoke? □ No □ Yes Do you vape? □ No □ Yes

Do you use recreational drugs? □ No □ Yes – please check below

□ marijuana □ prescription drugs □ opioids □ meth □ IV drugs □ other _____

Have you ever had surgery? □ No □ Yes – please list below

_____

_____

Do you have a family history of any of the following?

□ rheumatoid arthritis □ blood clots □ cancer, what type: _____

Review of Systems - check all that apply to you within the last 4 weeks:

□ Fever	□ Ringing in the ears	□ Neck pain
□ Sweats	□ Trouble swallowing	□ Back pain
□ Fatigue	□ Vision problems	□ Painful urination
□ Unexplained weight change	□ Wheezing	□ Rash
□ Congestion	□ Shortness of breath	□ Depression
□ Palpitations	□ Diarrhea	□ Easy bruising
□ Coughing	□ Constipation	□ Balance problems
□ Change in bowels	□ Chest pain	□ Anxiety
□ Heartburn	□ Headache	□ Seizures
□ Sleep disturbances	□ Dizziness	□ Tremors

By signing below, I am giving permission to the providers at Windward Orthopaedic Group to provide treatments needed for my care including injections, cast and brace applications, x-rays, or other treatments today and on follow up appointments.

Name of person completing form and relationship: _____

Patient or guardian's signature: _____ Date: _____