BEACON
Orthopaedics & Sports Medicine

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Patient Name: ______________________________ Age:_________ Female Male Today's Date:_____/_____/_____
Dominant Hand ☐ R ☐ L Height:________ Weight:__________ Occupation:______________
Who requested that you visit this office? ☐ Doctor Name:________________ ☐ Self-Referral ☐ Attorney
Would you like to receive information by email? ☐ N ☐ Y Email Address______________________________
Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
1. * (Chief Complaint) Main reason for visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other
(If other please explain)
2. * (Location) What body part is involved? (check below)

		Shoulder	Elbow	Hand	Pelvis	Knee	Foot
☐ Neck	☐ R Arm	☐ R	☐ R	☐ R	☐ R	☐ R	☐ R
& radiates to	☐ L Arm	☐ L	☐ L	☐ L	☐ L	☐ L	☐ L
		Arm	Wrist	Finger	Hip	Ankle	Toe
☐ Back	☐ R Leg	☐ R	☐ R	☐ R	☐ R	☐ R	☐ R
& radiates to	☐ L Leg	☐ L	☐ L	☐ L	☐ L	☐ L	☐ L

3. * (Duration) How long has this problem been present? _______ ☐ Days ☐ Weeks ☐ Months ☐ Years
4. * Check the ONE box below that best describes how your problem started? Use the space to the right to answer the ONE question below the box you checked. Use as much space as needed.

☐ NO INJURY Onset was: ☐ Gradual ☐ Sudden COMMENTS:
Why do you think it started?____

☐ INJURY (From accident or sport NOT work or auto related)
Date:
Where & how did it happen?____
What sport?____
School:____

☐ INJURY AT WORK From a: ☐ Lift ☐ Twist ☐ Bend ☐ Pull ☐ Reach
Date:

☐ WORK RELATED (But NO injury)
Date:
How did your job cause this injury?____
____

☐ AUTO ACCIDENT
Date:
How was the car hit?____

Please check the box in each category that best describes your problem:

5. * On a scale of 1-10 please rate your pain (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)
6. * Quality of pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
7. * Timing of pain? ☐ Constant ☐ Comes & Goes(intermittent) Does the pain wake you from sleep? ☐ Y ☐ N
8. * Do you have? ☐ Swelling ☐ Brusing ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bowel / bladder
9. * Since my problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged
10. * What makes the symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting
☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing
11. * What makes it better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _______________________
12. * What medications have you taken for this problem? ____
13. * Which treatments have you tried? ____
14. * Were you seen in the Emergency Room for this problem? ☐ N ☐ Y Which ER and Date?_____________
15. * What tests have you had? ☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test(EMG/NCV)
16. * Have you already had surgery for this problem? ☐ N ☐ Y Surgeons Name______________ Date:_________
17. * Did you have any adverse reactions to the anesthesia? ☐ N ☐ Y
18. * Do you have any MEDICAL PROBLEMS? ☐ N ☐ Y (Please list or check below)

☐ Diabetes	☐ High Blood Pressure	☐ Heart Problems	☐ Blood Clots	☐ Asthma
☐ Bronchitis	☐ Emphysema	☐ Kidney Problems	☐ Hepatitis	☐ Thyroid Disease
☐ Ulcers	☐ Seizures	☐ Stroke	☐ Tuberculosis	☐ Rheumatoid Arthritis

Cancer: ______________________________ Other:____

19. * Do you have any ALLERGIES? ☐ N ☐ Y Please List____
20. * Did you bring any X-Rays or Discs with you today? | | ☐ N ☐ Y
21. * Did a physician place you off work? ☐ N ☐ Y
22. * Are you pregnant? ☐ N ☐ Y
23. * Who is your medical Doctor?____
24. * Please list any previous surgeries including the year____
25. * Do you use tobacco? ☐ N ☐ Y ☐ Former How frequently?________ per day _________ per week
26. * Do you consume alcohol? ☐ N ☐ Y ☐ Former How frequently?________ per day
27. * Do you consume caffeine? ☐ N ☐ Y How frequently?________ per day _________ per week
28. * Do you have a history of recreational drug use? ☐ N ☐ Y
29. * Describe your activity level ☐ Above average ☐ Average ☐ Sedentary
30. * How frequently do you exercise? ☐ 2-3 times/week ☐ 3-4 times/week ☐ 5 times/week ☐ Daily ☐ Never
31. * Do you have any hobbies?____

REVIEW OF SYMPTOMS

Have you ever had a prior problem with the same Orthopaedic condition you are here for today? ☐ N ☐ Y
Do you have OTHER JOINTS with ☐ Morning Stiffness, ☐ Swelling, or ☐ Pain?

Please check any that apply to YOU or mark NONE

☐ Heart Burn ☐ Nausea ☐ Vomiting ☐ Loss of Appetite ☐ Stomach pain with anti-inflammatory pills
☐ Excessive Thirst ☐ Heat/Cold intolerance ☐ Trouble Swallowing ☐ Fever ☐ Weight Loss ☐ Hoarseness
☐ Blood in Stool ☐ Easy Bleeding ☐ Easy Bruising ☐ Anemia ☐ Painful Urination ☐ Blood in Urine
☐ Blurred Vision ☐ Double Vision ☐ Vision Loss ☐ Headaches ☐ Dizziness ☐ Hearing Loss
☐ Chronic Cough ☐ Shortness of Breath ☐ Rash ☐ Skin Ulcers ☐ Lumps ☐ Psoriasis
☐ Chest Pain ☐ Palpitations ☐ Drug/Alcohol Addiction ☐ Depression ☐ Sleep Disorder

Please list any other medical conditions we should be aware of?____
____

Please check any that apply to YOU OR your IMMEDIATE family (Mother, Father or Siblings) & please specify as to which member of your family is afflicted

☐ AIDS/HIV ________	☐ COPD ________	☐ Depression ________	☐ Hepatitis ________
☐ Alcoholism ________	☐ Colon Cancer ________	☐ Diabetes ________	☐ Kidney Disease ________
☐ Alzheimers ________	☐ Lung Cancer ________	☐ Drug Abuse ________	☐ Osteoarthritis ________
☐ Anemia ________	☐ Breast Cancer ________	☐ Gout ________	☐ Seizures ________
☐ Asthma ________	☐ Prostate Cancer ________	☐ Heart Disease ________	☐ Ulcers ________
☐ Blood Clots ________	☐ Cancer(type)________	☐ Hypertension ________	☐ Osteopenia or Osteoporosis ________

List any others____
____

For Office Use Only

Reviewed by Dr. David Argo____ Date:____________________