MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

Today's Date: _____ **Patient's Name:** _____

Birth Date: _____

Thank you for completing this questionnaire. This information will assist your doctor and the outpatient staff to evaluate and treat your problem. This questionnaire is confidential and will be made a part of your medical record.

Please bring this questionnaire and any X-rays, other imaging and/or test reports to your appointment.

Name of person completing the form, if not the patient: _____

Relationship to the patient: _____

Referring MD: _____

Referring MD Address: _____ Phone: _____

Primary Care physician, if different than referring physician: _____

State your main complaint or problem: _____

_____

_____

What do you expect your visit to accomplish? _____

_____

When did your problem begin? _____

How did your problem start? (If injury, please describe): _____

_____

Describe any treatments, up to now, give dates, and treating providers name(s): _____

_____

_____

Where is your pain? _____

Is the problem getting better, worse or staying the same? (circle one)

What makes it worse? _____

What makes it better? _____

What **can't** you do because of this problem? _____

_____

What is the quality of your pain? aching, burning, numbness, pins & needles, stabbing, other: _____

How many hours a day do you have this pain? _____ Do you have pain at rest? ❒ YES ❒ NO

Does the pain radiate to anywhere else? ❒ YES ❒ NO If YES, where? _____

Please rate your pain level:

◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

None Worse possible

MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

Please complete the following information if your problem is the result of an on-the-job injury.

If this does not apply to you, please continue to the next page.

Work-related injuries: _____

Date of injury: _____ Location: _____

Employer at time of injury: Name: _____

Address: _____

_____

_____

_____

Phone #: _____

Insurance Company: Name: _____

Address: _____

_____

_____

_____

Phone #: _____

Adjuster: _____

Case #: _____

Are you applying for disability benefits? Yes ☐ No ☐

MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

PAST MEDICAL HISTORY:

Have you ever had or do you now have:

☐ High blood pressure
☐ Diabetes or problem with sugar
☐ Blood clots in your blood stream
☐ Asthma, or hay fever with wheezing
☐ Tuberculosis
☐ Cancer. Where?_____

☐ Arthritis
☐ Gout
☐ Osteoporosis
☐ Seizures/Epilepsy
☐ Sickle Cell Anemia

Other Disease of your:

☐ Lungs
☐ Blood
☐ Liver
☐ Kidney
☐ Heart

Are there other diseases we should know about?: _____

List all your current Medications:

Name	Dose	How Often

List all your current Allergies to:

Medications	Reaction	Other	Reaction

Do you have or suspect Latex Sensitivity? Yes ☐ No ☐

Have you ever had a Blood Transfusion? Yes ☐ No ☐

When? _____ Why?_____

When did you last have a Tetanus shot? Date_____

Have you ever had Problems with Anesthesia? Yes ☐ No ☐ If yes, describe: _____

Please list all surgeries you have had and the dates:

Please list all injuries, broken bones, etc., with dates and treatments:

Have you ever sought treatment for stress or have you ever been treated for a psychological disorder?_____

MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

FAMILY MEDICAL HISTORY:

	If alive:		**If deceased:**
Father:	Age:_____	HEALTH: (circle one) good fair poor	Age:_____
	Cause of poor health:_____		Cause:_____
Mother:	Age:_____	HEALTH: (circle one) good fair poor	Age:_____
	Cause of poor health:_____		Cause:_____
Siblings:	Age:_____	HEALTH: (circle one) good fair poor	Age:_____
	Cause of poor health:_____		Cause:_____
	Age:_____	HEALTH: (circle one) good fair poor	Age:_____
	Cause of poor health:_____		Cause:_____
	Age:_____	HEALTH: (circle one) good fair poor	Age:_____
	Cause of poor health:_____		Cause:_____
	Age:_____	HEALTH: (circle one) good fair poor	Age:_____
	Cause of poor health:_____		Cause:_____

Have your blood relatives had any of the following? (circle):

high blood pressure, heart disease, heart attacks, strokes, diabetes, tuberculosis, epilepsy, alcoholism, cancer, kidney disease, rheumatic fever, bleeding tendency, arthritis and/or gout, asthma, dropsy, nervous breakdown

SOCIAL BACKGROUND:

Handedness: ❑ Right ❑ Left ❑ Ambidextrous

Are you a smoker? Yes ☐ No ☐ Substance:_____ Amount: _____ How long:_____

Have you used street drugs? Yes ☐ No ☐ Substance:_____ How long:_____

Do you drink alcohol? Yes ☐ No ☐ Substance:_____ Drinks/week: _____

Highest education: _____

Have you ever lived outside the United States? Yes ☐ No ☐

If yes, where and for how long?: _____

Are you: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partners ☐

Number of children:_____ and their ages:_____

If not Married or with a Partner, do you live alone? Yes ☐ No ☐

If No, who lives with you?: _____

Type of Residence: House ☐ Apartment ☐ Other:_____

Does your Residence have Stairs/Steps?: Yes ☐ No ☐ If yes, approximately how many steps?:_____

Currently employed: Yes ☐ No ☐ If not, when did you last work?_____

Current occupation: _____

MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

COMPLETE REVIEW OF SYSTEMS: Do you now have or recently had:

CONSTITUTIONAL

YES NO HOW LONG?

☐ ☐ _____ Fever or Chills (circle which one)
☐ ☐ _____ Easily fatigued
☐ ☐ _____ Unexplained weight loss/gain
☐ ☐ _____ Unexplained decreased appetite
☐ ☐ _____ Nausea or Vomiting

CARDIOVASCULAR

YES NO HOW LONG?

☐ ☐ _____ Chest pain or Angina
☐ ☐ _____ Heart murmur
☐ ☐ _____ Irregular heart rate
☐ ☐ _____ Poor blood circulation
☐ ☐ _____ Leg/ankle swelling

ALLERGY/IMMUNOLOGY

YES NO HOW LONG? When exposed to allergens, do you get:

☐ ☐ _____ Sneezing, runny nose or Itching eyes
☐ ☐ _____ Hives or itchy rash
☐ ☐ _____ Difficulty breathing or swallowing
☐ ☐ _____ Are you allergic to metals? _____
☐ ☐ _____ Do you get sick or get infections frequently?

NEUROLOGICAL

YES NO HOW LONG?

☐ ☐ _____ Seizures or Tremor
☐ ☐ _____ Frequent headaches/migraines
☐ ☐ _____ Feeling faint or dizzy
☐ ☐ _____ Numbness or loss of sensation
☐ ☐ _____ Tingling or pain that radiates

HEMATOLOGIC/LYMPHATIC

YES NO HOW LONG?

☐ ☐ _____ Previous Deep Vein Thrombosis (leg clot)
☐ ☐ _____ Previous Pulmonary Embolism (lung clot)
☐ ☐ _____ Bleeding problems
☐ ☐ _____ Easy bruising
☐ ☐ _____ Enlarged lymph nodes (neck/arm pit/groin)

GASTROINTESTINAL

YES NO HOW LONG?

☐ ☐ _____ Diarrhea or Constipation
☐ ☐ _____ Abdominal pain
☐ ☐ _____ Leakage of bowel
☐ ☐ _____ Bloody stool

EARS, NOSE, MOUTH, THROAT

YES NO HOW LONG?

☐ ☐ _____ Loss of hearing
☐ ☐ _____ Nasal problems
☐ ☐ _____ Toothache/Bleeding gums/Sores
☐ ☐ _____ Difficulty swallowing or eating

MUSCULOSKELETAL

YES NO HOW LONG?

☐ ☐ _____ Difficulty moving any limb
☐ ☐ _____ Muscle wasting or Weakness
☐ ☐ _____ Swelling. Where? _____
☐ ☐ _____ One limb smaller/larger than the other

RESPIRATORY

YES NO HOW LONG?

☐ ☐ _____ Shortness of breath/difficulty breathing
☐ ☐ _____ Cough
☐ ☐ _____ Coughing up blood
☐ ☐ _____ Do you have a cold?

GENITOURINARY

YES NO HOW LONG?

☐ ☐ _____ Pain when you urinate
☐ ☐ _____ Frequent urination
☐ ☐ _____ Unable to control urination
☐ ☐ _____ Blood in urine

SKIN

YES NO HOW LONG?

☐ ☐ _____ Rashes or Sores
☐ ☐ _____ Slow to heal when injured
☐ ☐ _____ Lesions changing in size, shape or color

EYES

YES NO HOW LONG?

☐ ☐ _____ Recent change of vision

Other eye problem _____

MENTAL

YES NO HOW LONG?

☐ ☐ _____ Depression
☐ ☐ _____ Anxiety
☐ ☐ _____ Insomnia

ENDOCRINE

YES NO HOW LONG?

☐ ☐ _____ Excessive thirst or hunger
☐ ☐ _____ Cold or heat intolerance
☐ ☐ _____ Night sweats

Reviewed by: _____ Date: _____
Physician's Signature

_____
Printed Name