Colorado Springs Orthopaedic Group

csog.net

Date:_____ Name: _____ Age: _____

Primary Care MD:_____ Height:_____ Weight:_____

Condition	Yes	No	Condition	Yes	No	List all medications you currently take.
Tuberculosis			Fainting/dizziness/falls/imbalance			
Cancer			Pregnancy			
Ulcers			Hernia			
Low/High Blood Pressure			Fracture			
Bowel or Bladder Problems			Alcoholism/chemical dependency			
Neck Injury			Blood clots			
Back Injury			Kidney disease			
Arthritis/Joint Swelling			Epilepsy/Seizures			
Headaches/Migraines			Hearing loss/ringing in ears			
Hepatitis			Cataracts/Glaucoma/Macular			
Allergies/Asthma			Do you exercise regularly?			
Heart problems/Pacemaker/Chest Pain			Do you smoke?			
Diabetes/Neuropathy			Are you in a relationship where you are being hit, kicked, slapped or otherwise hurt?			
HIV/AIDS			Do you feel safe at home?			
Stroke/head/brain injury			Other:			
Shortness of breath						

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

_____

_____

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

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

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

First Episode: _____

Subsequent Episode: _____

Most Recent Episode:_____

How did your Injury/Symptoms Occur? _____

If you have pain please complete the follow pain scale:
(0-No Pain, 10-The Worst Pain You Can Imagine)

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