

BONUTTI CLINIC
HISTORY OF INJURY / COMPLAINT



THIS FORM MUST BE FILLED OUT COMPLETELY BEFORE SEEING THE DOCTOR. THANK YOU.

PATIENT NAME: _____ DATE: _____ DOB: _____

AGE: _____ MARITAL STATUS: _____ HAND DOMINANCE: RIGHT / LEFT (Please Circle)

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

PHYSICIAN SEEING TODAY AT BONUTTI CLINIC: _____ REFERRING PHYSICIAN: _____

EMERGENCY ROOM VISIT / LOCATION: _____ DATE OF INJURY: _____ LENGTH TIME PRESENT: _____

LOCATION OF PROBLEM: _____

HOW / WHAT HAPPENED? _____

WHAT MAKES YOUR PROBLEM WORSE? _____

WHAT MAKES YOUR PROBLEM BETTER? _____

EMPLOYER NAME: _____ YEARS EMPLOYED: _____ WORK COMP: YES / NO

JOB TITLE / TYPE OF WORK YOU PERFORM: _____

I hereby represent and acknowledge that all information provided herein is accurate and complete.

Patient Signature: _____ Date: _____ Time: _____

*****BELOW SECTION TO BE COMPLETED BY OFFICE STAFF ONLY*****

WHERE DID INJURY OCCUR? _____

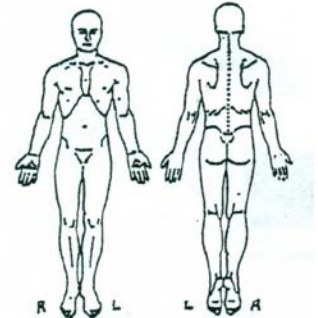
PRIOR TREATMENT: (✓ which apply) Medication [] X-ray [] MRI [] Injection [] Physical Therapy []

IF YOU ARE HAVING PAIN, RATE THE PAIN ACCORDING TO THE SCALE BELOW: (please circle) **Circle Where You Have Pain / Problem**

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
No Pain Severe Pain

Circle those that apply under each category

<u>Location</u>	<u>Quality</u>	<u>Duration</u>	<u>Associated Symptoms</u>	<u>Timing (when occurs)</u>
generalized	sharp	intermittent	bruising	at rest / sitting
localized	dull	constant	numbness / tingling	with activity
radiating site	stabbing		locking	at night / sleeping
	throbbing		swelling	other _____
	burning		none	
	aching			



Do You Use Alcoholic Beverages? Yes [] No []

Are You Pregnant? [] []

Do You Have Diabetes? [] []

Do You Smoke? [] []

_____ packs per day for _____ years

Do You Have Heart Disease? Yes [] No []

Have you seen a cardiologist? [] []

If **YES**, Cardiologist's Name: _____

Please circle those below that apply:

Stents Heart Attack Stroke Atrial Fib Heart Arrhythmia

Any other heart problems: _____

ALLERGIES: (List drug and/or other allergies with associated reaction) If none, please ✓ box

MEDICAL HISTORY: (List medical conditions) _____

SURGICAL HISTORY:(List any previous surgeries/hospitalizations) _____

FAMILY HISTORY: (List pertinent family history) _____

****THIS SIDE TO BE COMPLETED BY OFFICE STAFF ONLY****

NAME _____ DOB _____ DR. _____ DATE _____

CARRIER _____ Date Of OR / Injury _____

CC _____

Vitals: Height: _____ Weight: _____ BP: _____

Exam √ = Assessed

Const: well-developed well-nourished no acute distress vital signs

Eyes: Pupils Equal Sclera clear & white No petechia or jaundice

Lymph: No lymphedema

Card: Blood pressure Respirations - Not labored, No wheezing

Skin: No rashes, lesions or ulcers Warm & dry, normal turgor

Neuro/Psych: Alert oriented X 3 Normal mood

Musculo/Extrem: No atrophy or weakness No edema

Other _____

Diagnostic Testing XRAY / MRI / CT
Today or Date _____ Yes ___ No ___

Of: _____

of Views: _____

Findings:

HPI / Reason for Visit _____

Exam _____

ROM _____

Incision: Well approximated Well healed Skin intact _____

Gait: Normal Antalgic Flexed Stiff Shortened Other _____

Assistive Device: None Cane Crutches Walker Wheelchair _____

Difficulty with Stairs: No Difficulty Ascending Stairs Descending Stairs Both ascending / descending stairs _____

DX _____

Treatment / Follow-up _____
