CLEAR FORM

ORTHOPAEDIC SPECIALISTS

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Name _____ DOB _____ Age _____

SS# _____ ○ Male ○ Female

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____ Work _____

Email _____

Employer _____ Occupation _____

Spouse: Name _____ DOB _____

Emergency contact (name/phone) _____

Primary care provider _____
(Full name, city, state and phone)

Were you referred by a health care provider ○ No ○ Yes Name _____

MEDICAL HISTORY

Are you now or have you ever been diagnosed with: (check if yes)

- ☐ Anemia
- ☐ Asthma
- ☐ Blood clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Iritis/Uveitis
- ☐ Kidney disease
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

List hospitalizations / surgeries/ serious injuries: When?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY

	Current age, if living	Health problems	Cause of death and age
Father	_____	_____	_____
Mother	_____	_____	_____

PHARMACY

Preferred pharmacy _____

PRESENT MEDICATION: Please list all prescribed and over the counter medications, vitamins and supplements.

	Name of drug	Dose (strength and # per day)	How long have you taken this drug?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____

ALLERGIES	Describe reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS

Patient name _____ Date _____

Review the following list. Please check problems you have now.

General Symptoms
- ☐ None
- ☐ Anorexia
- ☐ Chills
- ☐ Confusion/disorientation
- ☐ Dizziness
- ☐ Drooling
- ☐ Edema
- ☐ Faintness
- ☐ Fatigue
- ☐ Heartburn
- ☐ Itching
- ☐ Malaise
- ☐ Nausea
- ☐ Weakness
- ☐ Other _____

Constitutional Symptoms
- ☐ None
- ☐ Fever
- ☐ Chills
- ☐ Other _____

Eye Symptoms
- ☐ None
- ☐ Eye pain
- ☐ Eye redness or drainage
- ☐ Double vision
- ☐ Other _____

Ears/Nose/Throat Symptoms
- ☐ None
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Vertigo
- ☐ Tinnitus
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Other _____

Skin Symptoms
- ☐ None
- ☐ Change in skin color
- ☐ Itching
- ☐ New lesions
- ☐ Nail changes
- ☐ Rash
- ☐ Other _____

Cardiovascular Symptoms
- ☐ None
- ☐ Chest pain/pressure at rest
- ☐ Chest pain/pressure with activity
- ☐ Claudication
- ☐ Dizziness
- ☐ Edema
- ☐ Fatigue
- ☐ Fluid retention
- ☐ Palpitations
- ☐ Other _____

Respiratory Symptoms
- ☐ None
- ☐ Cough
- ☐ No shortness of breath at rest
- ☐ No shortness of breath with usual activity
- ☐ Drooling
- ☐ Shortness of breath
- ☐ Other _____

Shortness of Breath Indicator
- ☐ Shortness of breath at rest
- ☐ Shortness of breath reclining
- ☐ Shortness of breath sitting straight up
- ☐ Shortness of breath with ordinary activity
- ☐ Shortness of breath with exercise

Gastrointestinal Symptoms
- ☐ None
- ☐ Abdominal tenderness
- ☐ Anorexia
- ☐ Belching
- ☐ Constipation
- ☐ Cramping
- ☐ Diarrhea
- ☐ Flatulence
- ☐ Heartburn
- ☐ Hiccupping
- ☐ Impaction
- ☐ Incontinence
- ☐ Nausea
- ☐ Stool, black/bloody
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Other _____

Genitourinary Symptoms
- ☐ None
- ☐ Anuria (very little urine output)
- ☐ Burning
- ☐ Decreased urine output
- ☐ Diuresing (increased urine production)
- ☐ Dribbling
- ☐ Dysuria (painful urination)
- ☐ Frequency
- ☐ Functional incontinence
- ☐ Hematuria (blood in urine)
- ☐ Hesitancy
- ☐ Impaired urge sensation
- ☐ Incontinence
- ☐ Nocturia (frequent urination at night)
- ☐ Oliguria (producing small amounts of urine)
- ☐ Polyuria (excessive urine output)

Genitourinary continued
- ☐ Penile discharge
- ☐ Retention
- ☐ Stress incontinence
- ☐ Unable to void (urinate)
- ☐ Urge incontinence
- ☐ Urgency
- ☐ Vaginal discharge
- ☐ Vulvar burning
- ☐ Change in urinary stream
- ☐ Menstrual irregularities
- ☐ Impotence
- ☐ Testicular pain
- ☐ Testicular mass
- ☐ Penile lesions
- ☐ Other _____

Neuromuscular Symptoms
- ☐ None
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Other _____

Breast Symptoms
- ☐ None
- ☐ Breast skin changes
- ☐ Nipple discharge
- ☐ Breast mass
- ☐ Breast pain
- ☐ Other _____

Neurological Symptoms
- ☐ None
- ☐ Concentration difficulties
- ☐ Confusion/Disorientation
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Facial droop
- ☐ Faintness
- ☐ Garbled speech
- ☐ Loss of consciousness
- ☐ Loss of consciousness witnessed
- ☐ Memory problems
- ☐ Slurred speech
- ☐ Tremors/shaky
- ☐ Visual changes
- ☐ Weakness
- ☐ Other _____

Usual Hours of Sleep _____

Suicidal Ideation
- ☐ None
- ☐ Intermittent
- ☐ Constant
- ☐ Vague
- ☐ Plan

Psychological Symptoms
- ☐ None
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Other _____

Endocrine Symptoms
- ☐ None
- ☐ Hair loss
- ☐ Appetite changes
- ☐ Cold/Heat intolerance
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Other _____

Hem/Lymph Symptoms
- ☐ None
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Swollen glands
- ☐ Bleeding gums
- ☐ Other _____

Allergic/Immunologic Symptoms
- ☐ None
- ☐ Eczema
- ☐ Hives
- ☐ Hayfever
- ☐ Other _____

Height _____

Weight _____

Shoe size _____

Tobacco History
- ☐ Current Use (select one):
- ☐ Current every day smoker
- ☐ Current some-days smoker
- ☐ Former smoker
- ☐ Never a smoker
- ☐ Type (select those that apply):
- ☐ Cigarettes
- ☐ Cigars
- ☐ E-cigarettes
- ☐ Oral
- ☐ Pipe
- ☐ Other _____

Tobacco use per day: _____

Number of years: _____

Alcohol and Drugs
- ☐ I drink alcohol
  Drinks per week: _____
- ☐ I don't drink alcohol
- ☐ I currently use illicit or intravenous drugs
- ☐ I have used illicit or intravenous drugs but I don't use them now

Miscellaneous
- ☐ I exercise regularly

Type: _____

_____

Amount per week: _____