LAFAYETTE
Orthopaedic Clinic
A UNITY HEALTHCARE PARTNER

Dr. Torok Box
Referral?
H:
Wt:
Pulse:
Resp:
RHD LHD

Date: ______________________________

Patient Name: ___________________________________ Age: ______

Who referred you to Orthopaedics? ____

Who is your Primary Care Doctor? ____

What hurts?____

When did it start (or Injury Date)? ____

Was there an injury? Yes No What happened? ______________________________
____
____

How bad does it hurt on a scale of 1 to 10: 1 2 3 4 5 6 7 8 9 10

How often is the pain present? Intermittent Frequent Continuous

How would you describe the pain? Sharp Dull Throbbing Numb Tingling Other ________________

Is it getting better or worse? Improving Worsening Staying the same

What makes it feel better? ____

What makes it feel worse? ____

Has another doctor started a work-up of this problem? Yes No
If yes, what was done or tried? ____

What other medical problems do you or did you have?

High Blood Pressure	Diabetes	Kidney Failure	Stroke
Rheumatoid Arthritis	Gout	Heart Disease	Asthma
Stomach Ulcers	Cancer	Heart Attack	HIV/AIDS
Hepatitis	Other: ______________________		

What medications do you take:

__________________ __________________ __________________
__________________ __________________ __________________
__________________ __________________ __________________

Are you allergic to any medicines or shell fish or latex? What happens?

Bad Medicine	Reaction
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________

OVER PLEASE

What surgeries have you had (approximate dates)

______________________________ ____________________________________
______________________________ ____________________________________
______________________________ ____________________________________

Do any medical problems run in your family?

Rheumatoid Arthritis Heart Disease Cancer Anesthetic Problems
Osteoarthritis (regular arthritis) Diabetes Other ______________________________

Social History:

Do you use tobacco? No Yes
If yes: Smoke Chew How much _________ # of years ________________

Do you drink alcohol? No Yes
If yes: How much: _________________________

Marital Status:

Married Widowed Divorced Single

Who’s around to help you out while you’re not feeling well?

No one Spouse Family Roommate

I am:

- ☐Employed Employer: ______________________ Occupation ___________________________
- ☐Retired
- ☐On disability Why: ____
- ☐In college Studying: ____
- ☐Just a kid…don’t ask me such hard questions!

For Minors:

Do Mom and Dad both live at home? Yes No
Where do you go to school? What grade? ____
What are you going to be when you grow up? ____

Any other medical problems? (Please circle)

Head
- Hearing loss
- Vision loss
- Dizzy spells

Heart/Lungs
- Chest pain/pressure
- Palpitations
- Wheezing
- Shortness of breath

Skin
- Any infections anywhere?

GI
- GI Bleeding
- Stomach upset with medicines
- Blood in stool

Urinary System
- Frequent urinary infections
- Burning with urination
- Blood in urine

Weight
- Unintentional weight loss
- Unintentional weight gain