USE PATIENT PLATE

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

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

Please complete 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.

Birthdate: _____

Name of person completing the form: _____

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): _____

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? _____

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

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Please complete the following information if your problem is the result of an on-the-job injury or if you have retained an attorney because of this problem or if you expect to receive disability or worker's compensation.

Work-related injuries: _____

Date of injury: _____ Location: _____

Employer at time of injury: Name: _____

Address: _____

_____

_____

_____

Phone #: _____

Insurance Company: Name: _____

Address: _____

_____

_____

_____

Phone #: _____

Adjuster: _____

Case #: _____

Any litigation pending? Yes _____ No _____ If yes, describe: _____

_____

_____

_____

Are you applying for disability benefits? Yes _____ No _____

_____

_____

PAST 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

Disease of your:

_____ Blood
_____ Liver
_____ Kidney
_____ Heart

Cancer _____ Part of body _____

_____ Other diseases we should know about: _____

_____

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List all your current medications:

Name	Dose	How Often

List all your current allergies to:

Medications	Other

Do you have or suspect latex sensitivity? Yes _____ No _____

Are you a smoker? Yes _____ No _____

Substance:_____ Amount: _____ How long:_____

Have you used street drugs? Yes _____ No _____

Substance:_____ Amount: _____ How long:_____

Have you ever had a blood transfusion? Yes _____ No _____

When? _____ Why?_____

When did you last have a tetanus shot? Date_____

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?_____

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FAMILY MEDICAL HISTORY:

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

Cause of poor health:_____

_____

_____

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

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

SOCIAL BACKGROUND:

Highest education: _____

Have you ever lived outside the United States? Yes _____ No _____
If yes, state where and for how long:_____

_____

Are you: Married_____ Divorced_____ Single_____ Widowed_____

Are you sharing a residence? Yes _____ No _____

If yes, is that person's health: Good_____ Fair_____ Poor_____

Where do you live: location:_____

Residence: House_____ Apartment_____ Other:_____

Phone:_____

Miles to nearest family or friends:_____

Number of children:_____ and there ages:_____

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REVIEW OF SYSTEMS:

Are you easily fatigued?	YES	NO	HOW LONG?_____
Unexplained weight loss or gain? (Circle One)	YES	NO	HOW LONG?_____
Do you have a fever?	YES	NO	HOW LONG?_____
Do you have chills?	YES	NO	HOW LONG?_____
Do you have unexplained decreased appetite?	YES	NO	HOW LONG?_____
Do you have an irregular heart rate?	YES	NO	HOW LONG?_____
Have you ever had a heart murmur?	YES	NO	HOW LONG?_____
Do you have difficulty exercising due to weakness?	YES	NO	HOW LONG?_____
Do you have chest pains?	YES	NO	HOW LONG?_____
Do your ankles swell constantly?	YES	NO	HOW LONG?_____
Do you feel like you might faint or feel light-headed?	YES	NO	HOW LONG?_____
Do you have unusual headaches?	YES	NO	HOW LONG?_____
Have you ever had a seizure?	YES	NO	HOW LONG?_____
Have you ever been paralyzed?	YES	NO	HOW LONG?_____
Do you feel short of breath?	YES	NO	HOW LONG?_____
Do you have trouble breathing with an exercise?	YES	NO	HOW LONG?_____
Do you have a cough?	YES	NO	HOW LONG?_____
Are you coughing up blood?	YES	NO	HOW LONG?_____
Do you have a cold?	YES	NO	HOW LONG?_____
Do you have pain when you urinate?	YES	NO	HOW LONG?_____
Do you have or have you had blood in your urine?	YES	NO	HOW LONG?_____
Are you urinating too often?	YES	NO	HOW LONG?_____
Do you feel like you have to urinate all the time?	YES	NO	HOW LONG?_____
Are you unable to control your urine?	YES	NO	HOW LONG?_____
Do you feel sick to your stomach?	YES	NO	HOW LONG?_____
Have you thrown up, had diarrhea, or constipation recently?	YES	NO	HOW LONG?_____
Have you passed blood with bowel movements?	YES	NO	HOW LONG?_____
Have you ever had tarry stools?	YES	NO	HOW LONG?_____
Have you ever had ulcers?	YES	NO	HOW LONG?_____
Have you ever been jaundice?	YES	NO	HOW LONG?_____
Have you ever had gallstones?	YES	NO	HOW LONG?_____
Do you have difficulty moving any limb?	YES	NO	HOW LONG?_____
Do you have weakness in any limb?	YES	NO	HOW LONG?_____
Are any of your muscles wasting?	YES	NO	HOW LONG?_____

Reviewed by: _____ Date:_____
Provider's Signature

_____
Printed Name