Name: _____

DOB: _____

Age: _____

Date: _____

COLUMBUS COMMUNITY HOSPITAL

Rosemary Buckle, MD
Orthopedics

Ht:_____
Weight: _____
BP: _____/_____
Pulse: _____
Temp:_____

Office use only

Why are you here today? _____

_____

_____

When did the problem start? _____

If you have an injury, did it occur on the job? YES NO

Treatments tried up to this point:

PILLS CREAMS INJECTIONS PHYSICAL THERAPY SURGERY

Do you require a brace or assist device for mobility? YES NO If YES, please circle below:

CANE WALKER ROLLATOR WHEELCHAIR CRUTCHES SCOOTER BRACE

PAST MEDICAL HISTORY: Please circle if you have had any of the following:

Anxiety	Depression	Thyroid Problems	Sleep Apnea	Gout	Reflux
Asthma	COPD	High blood pressure	Kidney Disease	Dialysis	Diabetes
Neuropathy	Cancer	Heart Disease	Blood Clot	Pulmonary embolism	
High cholesterol		HIV	Hepatitis	COVID 19	
Rheumatoid arthritis		Pacemaker	Other implantable device		

DO YOU HAVE ANY OTHER MEDICAL ISSUES NOT LISTED?

_____

Are you taking a blood thinner? _____ **Have you ever had a stomach ulcer?** _____

Are your kidneys working normally? _____**Do you take NSAIDS (i.e. Aleve, Motrin) OTC?** _____

HAVE YOU HAD ANY SURGERIES?: **Yes** **No** If yes, please list below (with approximate year)

_____

_____

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS: (Over the counter AND Prescription):

_____

_____

ALLERGIES: _____

REACTION: rash difficulty breathing Other_____

DO YOU HAVE A PAIN MANAGEMENT PHYSICIAN? Yes No

Name: _____

REVIEW OF SYSTEMS: Please circle if you have experienced any of the following within the past week:

Headache Chest pain Shortness of breath Nausea Vomiting Fever Chills

Cough Back pain Leg swelling Numbness Tingling Weakness

Weight gain Weight loss Vision Change Difficulty hearing Dizziness

PLEASE CIRCLE IF ANYONE IN YOUR FAMILY HAS HAD ANY OF THE FOLLOWING:

Diabetes Cancer Heart disease Blood clot Stroke

CIRCLE IF YOU: Smoke tobacco Drink alcohol Use street drugs None

OCCUPATION: _____ retired disabled

PLEASE CIRCLE IF YOU ARE: right handed left handed

PLEASE CIRCLE BELOW IF YOU HAVE HAD A:

FLU VACCINE: Yes No If yes, when? _____

COVID-19 VACCINE: Yes No If yes, when? _____

HEMOGLOBIN A1C LEVEL : Yes No If yes, what was the most recent result? _____%