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? _____

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

BIRTH: Full Term Premature **BIRTH WEIGHT**: _____

DELIVERY: Normal C-Section Breech **WHAT NUMBER CHILD?** 1st 2nd 3rd 4th

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

Anxiety Reflux Asthma Juvenile Diabetes Cancer COVID 19

Juvenile Rheumatoid arthritis

DO YOU HAVE ANY OTHER MEDICAL ISSUES NOT LISTED?

_____

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

_____

_____

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

_____

_____

ALLERGIES: _____

REACTION: rash difficulty breathing Other_____

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

Headache Shortness of breath Nausea Vomiting Fever Chills

Cough Rash Tingling Weakness Limp Joint swelling

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

GRADE IN SCHOOL: _____ **SPORTS**:_____

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? _____

TETANUS SHOT: Yes No If yes, when? _____