S. Robert Rozbruch, MD
Orthopaedic Surgery

Please note that it is a requirement for the physician to document this information. Please answer all questions. Answer "none" if appropriate.

Date: _____

Name: _____ Email: _____

Home #: _____ Cell # _____Work #: _____

Birth Date: _____ Age: ____ Height: _____ Weight: _____ Blood Pressure: _____

Chief Complaint: _____

Primary MD (Name, Phone Number): _____

Referral Information:
Who referred you to Dr. Rozbruch? _____

Are they a former patient of this office? _____

Information on the doctor(s) to whom you would like a report sent:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____

Did this doctor refer you here? _____

History of Present Illness:
Location: Where is the pain? _____

Quality: Circle one or more: sharp dull aching shooting traveling

Timing: When did it first start? _____

Is this a Work, Pedestrian or Motor Vehicle related injury? _____

Context: What causes the pain? _____

Frequency: How many times per week is it a problem? _____

Modifying Factors: What makes it worse? _____

What helps make it better? _____

Prior Treatment: _____

Past Medical History:
Major illness or injury: _____

Past Surgery: _____

Current Medications and what they are used to treat:

_____ _____

_____ _____

_____ _____

Allergies to medications: _____

Other Allergies ie. food: _____

Family History:

Medical Conditions that have been in your family: _____

Social History:

Marital Status: _____ Occupation: _____

Are you currently working? _____ If No, last date of work: _____

Alcohol use: How many drinks per week? _____

Smoking: How many packs per day? _____

Person you wish doctor to call in case of emergency or after surgery:

Name/Relation: _____ Telephone: _____

Person(s) able to be of assistance after surgery (explain): _____

_____

Review of Systems:

Please list any problems in the following systems: Indicate "none" if appropriate.

Cardiovascular, Heart: _____

Ear, Nose, Throat: _____

Endocrine, Hormonal, Diabetes: _____

Eyes: _____

Gastrointestinal, Digestive system, Liver: _____

Genitourinary: _____

Hematologic, Blood: _____

Immunologic, Immune compromise: _____

Integumentary, Skin: _____

Neurologic: _____

Peripheral circulation: _____

Psychiatric: _____

Renal, Kidney: _____

Respiratory, Lungs: _____

Do you have Sleep Apnea? _____ If Yes, do you use a CPAP/BIPAP? _____

Other:

Infection History-

Do you have a history of infection? _____ If Yes, what kind/When? _____

Name/Type of Antibiotics used, Duration? _____

Infectious Disease MD (Name, Phone Number): _____

Pain Management History-

Have you been followed by a Pain Management MD? _____ If Yes, current or past? _____

Name of Pain Medications and for how long? _____

_____

Pain Management MD (Name, Phone Number): _____