AUGUSTA ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS P.C.

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Patient Name _____ DOB _____

Pharmacy _____ Date _____

Visit Information

Reason for visit: _____ Referring Physician _____

Primary Care Physician _____

Type of pain: ☐ Ache ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click / Pop Date of Injury: ____/____/____

Severity: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable Duration of pain: _____ Location of pain: _____ %

_____ %

Pain Aggravated By:

☐ Standing ☐ Walking ☐ Lying
☐ Sleeping ☐ Working ☐ Stairs
☐ Sitting ☐ Driving

Treatments Attempted:

☐ Pain Medications ☐ Anti-Inflammatory ☐ Rest
☐ Wheelchair ☐ Physical Therapy ☐ Ice
☐ Surgery ☐ NONE

Medications

Please list any medications that you currently use, including over-the-counter medications, vitamins, herbs, and prescribed drugs.

Medications:	Dose:	Medications:	Dose:
		☐ None	

Allergies

Known Drug Allergies:

☐ None Known ☐ Iodine ☐ Diagnostic Dyes ☐ Morphine
☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Ibuprophen
☐ Sulfa Drugs ☐ Acetaminophen ☐ Latex
☐ Other: _____

Height _____ Weight _____

Please Circle One

ETHNICITY:

African Irish Jewish Not Hispanic or Latino
Cuban Italian Native American Polish
Hispanic or Latino

RACE:

White Chinese Japanese Guamanian
Black Filipino Vietnamese Samoan
American Indian Hispanic Hawaiian

PREFERRED LANGUAGE:

English Spanish