

Patient Name:

Patient Chart #



PINNACLE

**1818 East 23rd Avenue
Hutchinson, KS 67502
620-662-6000 or Toll Free 1-877-662-6001**

SPORTS MEDICINE & ORTHOPAEDICS

Visit Date: ___ / ___ / ___

JLL ELS TP Other Provider: _____

Name: _____ DOB: ___ / ___ / ___ AGE: _____

Current History

What is the main reason you came to the office today?

Details Relevant to Your Visit

Was your visit caused by an Accident/Injury? Yes No Not Applicable

Accident/Injury Date (month/day/year) (___ / ___ / ___)

Provide details on how the accident or injury occurred.

Where did the accident/injury occur? Work Home Auto Other _____

Is this a workers' compensation or auto claim? Workman's Comp Auto Neither

Is an attorney involved? Yes No

Attorney Name

Attorney Phone

X-Rays Did you have X-rays taken at another location ? Yes No X-Ray Date ___ / ___ / ___

Where were the X-rays taken Do you have the X-rays with you? Yes No

What is your usual work (describe)?

What sports, hobbies, leisure or activities do you engage in?

Name of primary care physician:

Name of referring physician:

We will be sending a letter to your referring physician. Do you want a letter sent to any other physician regarding your visit today? Yes No

Name of physician to whom you want the letter sent:

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Past Medical History

Do you have any chronic medical problems or current medical problems? Yes No.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Latex Sensitive	<input type="checkbox"/> Other:	<input type="checkbox"/>

When was the first day of your last menstrual period: Not Applicable Date (/ /)

Have you ever had any sexually transmitted diseases? Yes No
(If yes, please circle: Gonorrhea, Chlamydia, Hepatitis B, Hepatitis C, HIV/AIDS, Syphilis)

Past Medical History

List any surgeries you have had:

Year	Surgery

List prior hospitalizations (other than surgeries or deliveries):

Year	Cause/Illness

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Family History

Does anyone in your immediate or extended family have any of the following problems:

<i>Disease</i>	<i>Yes/No</i>	<i>Who</i>	<i>Describe</i>
Diabetes			
Heart disease			
High cholesterol			
Strokes			
High blood pressure			
Osteoporosis or weak bones or broken hips			
Alzheimer's			
Blood clots in legs, lungs or brain			
Cancer			
Alcohol or drug use			
Bleeding disorders			

Social History

What race are you?	Are you: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No. How much?	How long?
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No. How much?	
Have you ever used any street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No.	
<i>When</i>	<i>What</i>

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Review of Systems Please mark any of the following symptoms that you currently have **No concerns with these**

<input type="checkbox"/> Recent weight change <i>Specify:</i>	<input type="checkbox"/> Cough	<input type="checkbox"/> Pain or discomfort with urination
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Skin rashes or sores	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Incontinence (loss) of stool or gas
<input type="checkbox"/> Unusual headaches	<input type="checkbox"/> Earaches	<input type="checkbox"/> Leg cramps
<input type="checkbox"/> Fainting	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Head injuries	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> History of blood clots in legs/lungs
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Back problems
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Intolerance to heat or cold
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Mitro Valve Prolapse	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Depression
<input type="checkbox"/> Lumps in neck	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Change in bowel movements
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Bloody or black tarry stools
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Constipation/Hemorrhoids	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Numbness (location)	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Artificial Joint
	<input type="checkbox"/> Tingling (location)	

List any medications you are taking:	
Prescription:	<input type="checkbox"/> None
Non-Prescription (include vitamins, supplements, herbs, etc.)	<input type="checkbox"/> None
Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No.	
Describe/List	