Orlin & Cohen Medical Specialists Group

Patient Label

PATIENT POST-OP/FRACTURE CARE/INJECTION FORM

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports / Light Duty / Not working due to injury

Please fill out this section if you are a Post-Op or Fracture Care patient

Is this a post-surgical visit? ❑ Yes ❑ NO If yes, surgery date_____________ Type of surgery (list side)__________________________

If fracture care, Body Part Injured: ❑ LEFT ❑ RIGHT_________________

Date of Injury/Accident/Onset: ____________________________________ Cause: Sports/Work/MVA/Other

Pain at Rest: **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** Pain at Activity: **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

Please fill out this section if you are having an Injection today

Have you ever had an injection before ❑ Yes ❑ NO Date of last injection: ____

If this is an injection series what # was your last injection? ❑ # 1 ❑ # 2 ❑ # 3 ❑ # 4 ❑ # 5

Type of injection (*circle*) Supartz Synvisc Orthovisc Gel One Steroid Hyalgan Synvisc One Other_________________

Did you ever have any reaction to the Injection/s? ❑ Yes ❑ NO What was the reaction:__________________________________

If you had an Injection did it help you with your pain? ❑ Yes ❑ NO

What percentage did it help? (*Please circle*) 0 10 20 30 40 50 60 70 80 90 100%

MEDICAL HISTORY: ❑ No changes since last visit.

List any changes to your medical history since your last visit: ____

____

List any new medications since your last visit: ❑ None:____

Current School: ____ Sports/Occupation:_____________________________________

Include School & Grade Level — Include Positions Played

REVIEW OF SYSTEMS: (Check All That Apply)

GENERAL
- ❑ Weight Change
- ❑ Fever or Chills
- ❑ AIDS/HIV
- ❑ Night Sweats
- ❑ Bleeding
- ❑ Lumps or Masses
- ❑ Dizziness or Fainting
- ❑ Diabetes Mellitus
- ❑ Heart Disease
- ❑ Cancer

SKIN
- ❑ Itching or Rash
- ❑ Thyroid Problem

GASTROINTESTINAL
- ❑ Difficulty Swallowing
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Reflux
- ❑ Ulcer

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Numbness
- ❑ High Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Thrombophlebitis/DVT/PE

GENITOURINARY
- ❑ Urinary Infections
- ❑ Incontinence
- ❑ Urinary Frequency
- ❑ Venereal Disease
- ❑ Menopause

NEUROLOGIC
- ❑ Seizures
- ❑ Joint Pain
- ❑ Weakness

EAR-EYES-NOSE-THROAT
- ❑ Visual Change
- ❑ Hearing Change
- ❑ Tinnitus
- ❑ Bleeding Gums

MUSCULOSKELETAL
- ❑ Back Ache
- ❑ Wound Discharge
- ❑ Joint Swelling

RESPIRATORY
- ❑ Cough/Sputum
- ❑ Tuberculosis
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema

PSYCHOLOGICAL
- ❑ Depression
- ❑ Bipolar
- ❑ ADD/ADHD
- ❑ Other___________

❑ All systems received & negative

Pharmacy Information Sheet ❑ Unchanged since last visit

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

Your Name:		Date of Birth:
Pharmacy Name:		
Address:		
City:	State:	Zip:
Pharmacy Phone #:	Pharmacy Fax:	

______________________ Patient/Guardian Signature ____________ Date ______________________ Physician's/PA Signature ____________ Date