Methodist Center for Orthopaedic Surgery

Evan D. Collins, M.D. Department of Orthopedic Surgery

Name_____ **Today's Date**_____

Date of Birth_____ **E-Mail address**_____

Referring Physician_____ **Referring Physician #**_____

Employer_____ **Employer's #**_____

Gender: Male / Female **Dominant Hand:** Left / Right **Affected Hand Problem:** Left / Right

Reason for your visit today: _____

_____

_____

Please circle any symptoms you may have:

Fatigue	Y	N	Muscle or joint pain	Y	N	
Weight change	Y	N	Muscle or joint stiffness	Y	N	
Skin rashes or sores	Y	N	Muscle or joint swelling	Y	N	
Changes to nails	Y	N	Muscle or joint weakness	Y	N	
Cough	Y	N	Limited range of motion	Y	N	
Nervousness	Y	N	History of arthritis	Y	N	
Hot or cold intolerance	Y	N	History of trauma	Y	N	
Excess sweating	Y	N	Numbness	Y	N	
Easy bruising	Y	N	Tingling	Y	N	

Please circle any of the medical problems you have or had in the past:

Heart Problems	Y	N	High Blood Pressure	Y	N	Cancer, type:			
Blood Clots	Y	N	Irregular Heart Beat	Y	N	Arthritis, location:			
Thyroid Problems	Y	N	Diabetes	Y	N	Childhood Diseases:			
Asthma	Y	N	Hepatitis	Y	N	Psychiatric Problems:			
Tuberculosis	Y	N	Peptic Ulcers	Y	N	Bleeding Problems	Y	N	
Hiatal Hernia	Y	N	Pneumonia	Y	N	Colitis	Y	N	
Kidney Infection	Y	N	Urinary Infection	Y	N	Blood transfusion	Y	N	
Kidney Stones	Y	N	Gallbladder Problems	Y	N	HIV/Aids	Y	N	

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Are you pregnant? yes no **Last menstrual period**_____

Social History

Do you smoke? yes no **If so, how much?**_____

Do you drink alcohol? yes no **If so, how much?**_____

Do you take drugs? yes no **If so, how much?**_____

Please circle any of the following medical problems that anyone in your immediate family has/had (Mother, Father, Sister, and Brother):

Arthritis	M	F	S	B	Diabetes	M	F	S	B
High blood pressure	M	F	S	B	Asthma	M	F	S	B
Heart Problems	M	F	S	B	Cancer	M	F	S	B
Lund Disease	M	F	S	B	Bleeding Problems	M	F	S	B
Peptic Ulcers	M	F	S	B	Psychiatric Problems	M	F	S	B
Tuberculosis	M	F	S	B	HIV/Aids	M	F	S	B
Kidney Problems	M	F	S	B	Alcoholism	M	F	S	B
Colitis	M	F	S	B	Drug Abuse	M	F	S	B
Hepatitis	M	F	S	B	Other Infection	M	F	S	B

Please list any surgeries that you have had, including date of service:

_____

_____

List all ALLERGIES including medications, bandages/tape, and topical agents:

_____

_____

List all MEDICATIONS you are currently taking, including over the counter medications:

_____

_____

Please list any other information you feel the doctor needs to know:

_____

_____

_____

_____

_____