MUSC Health
MEDICAL UNIVERSITY of SOUTH CAROLINA
96 Jonathan Lucas Street, Charleston, SC 29425

Orthopaedic Surgery: *Initial Consultation*

Patient Identification Area

Name: ______________________________________ **Age:** ______ **Date of Birth:** _______________

Occupation/ Job: _____________________________ **Email:** ____________________________________

Where and what are your problem(s)? *(In Row 1 please check all body parts for which you are being seen. In Row 2, check the box showing which side(s) are affected. In Row 3 check all problems that apply.)*

1	❑ SHOULDER	❑ ELBOW
2	❑ Right ❑ Left ❑ Both	❑ Right ❑ Left ❑ Both
3	❑ Pain ❑ Weakness ❑ Unstable/ giving way/ dislocation ❑ Stiffness ❑ Swelling ❑ Other	❑ Pain ❑ Weakness ❑ Unstable/ giving way/ dislocation ❑ Stiffness ❑ Swelling ❑ Other

Which hand do you write with? ❑ Right ❑ Left

How would you rate the joint(s) you are being seen for today as a percent of normal (0-100%) with 100% being completely normal?
Joint: _____________ __________% Joint: _____________ __________%

Tell us about how or when your injury or problem began?
❑ No injury- just started hurting ❑ Motor vehicle accident
❑ Sports (*which sport?)* _____________ ❑Work/ Job

Date injury/ problem began: _______________ Please briefly describe the injury/ cause of the problem:
____

Please list previous treatments you've had for this problem:
❑ Medications ❑ Injection ❑ Physical Therapy ❑ Other: _________________________________
Did it help? ____

Have you had previous surgery for this problem? ❑ Yes ❑ No Surgery & Date: __________________________________

How severe is the pain? (0 = none, 10 = severe) *Please make an ✘ in the box that best represents your pain*

At rest:

1	2	3	4	5	6	7	8	9	10

At its worst:

1	2	3	4	5	6	7	8	9	10

Do you have pain at night? ❑ Yes ❑ No
Does the pain awaken you from sleep? ❑ Yes ❑ No
Are you currently working? ❑ Yes ❑ No *If yes, is it your* ❑ Normal job? ❑ Limited/ light duty?

What makes the problem better? ____
____

What makes the problem worse? ____
____

Describe activities you have trouble with or are unable to do because of your problem: ________________________
____

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GENERAL INFORMATION

SURGICAL HISTORY:

Surgeries/ Hospitalizations	Year	Complications

MEDICATIONS:

Current medication(s)	Dose	Frequency

Medical history:

Do/ did you have heart disease? ❑ Yes ❑ No
Do/ did you have ulcers/ gastritis? ❑ Yes ❑ No
Do/ did you have diabetes? ❑ Yes ❑ No
Do/ did you have liver problems? ❑ Yes ❑ No
Do/ did you take blood thinners? ❑ Yes ❑ No

Are you allergic to any medications? (*List medication and reaction)* ____
____

Latex allergy? ❑ Yes ❑ No

Other allergies? (List allergy and reaction) ____
____

Family history: ❑ Problems with anesthesia ❑ Bleeding and blood clotting disorder

Social history:

Do you smoke? ❑ Yes, I've smoked _____ packs of cigarettes per day for ______ years
❑ Yes, I smoke cigars or a pipe
❑ No, I have never smoked
❑ No, I quit _____ years ago. At that time, I was smoking ___ packs of cigarettes per day for ______ years

Do you drink alcohol?
❑ No, never (or rarely) ❑ No, but I used to
❑ Yes *How often?* ❑ Daily ❑ 1 or more times/ week ❑ 1 or more times/month

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Are you currently or have you ever had problems with:

HOW YOU FEEL	CIRCLE ONE	
Fever	Yes	No
Unexpected Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No
Loss of appetite	Yes	No
YOUR EYES		
Wear glasses or contacts	Yes	No
Infections	Yes	No
Injuries	Yes	No
YOUR YEAR, NOSE, THROAT & MOUTH		
Wear hearing aids	Yes	No
Date of last exam: ___________		
Hearing loss	Yes	No
Ear infections	Yes	No
Balance disturbance	Yes	No
Sinus problems	Yes	No
YOUR HEART		
Chest pain or angina	Yes	No
Date of last EKG: _____________		
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
Heart attack	Yes	No
Blood clots	Yes	No
YOUR LUNGS		
Asthma	Yes	No
Chronis cough	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Tuberculosis	Yes	No
Sleep Apnea	Yes	No
YOUR STOMACH & INTESTINES		
Nausea	Yes	No
Vomiting	Yes	No
Ulcers or gastritis	Yes	No
Colon cancer	Yes	No
Stomach ulcer	Yes	No
Hepatitis	Yes	No
YOUR KIDNEYS & URINE		
Urinary tract infection	Yes	No
Kidney stones	Yes	No
Kidney disease	Yes	No

YOUR MUSCLES & BONES	CIRCLE ONE	
Broken bones	Yes	No
List: _______________________		
Arm or leg weakness	Yes	No
Back pain	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling/ arthritis	Yes	No
Numbness	Yes	No
Osteoporosis	Yes	No
Instability/ giving way/ dislocation	Yes	No
Stiffness	Yes	No
Scoliosis	Yes	No
Spinal conditions	Yes	No
YOUR SKIN		
Skin cancer	Yes	No
Skin ulcers	Yes	No
YOUR BRAIN & NERVES		
Fainting spells or "blacking out"	Yes	No
Seizures	Yes	No
Coordination in arm and / or legs	Yes	No
Stroke	Yes	No
Balance problem	Yes	No
Headaches	Yes	No
YOUR GLANDS		
Diabetes	Yes	No
Treatment: ________________		
Thyroid Disease/ Disorder	Yes	No
Hormone Problems	Yes	No
YOUR BLOOD		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands/ Lymph Nodes	Yes	No
Blood Transfusion	Yes	No
If yes, when? _______________		
Easy bleeding	Yes	No
Easy bruising	Yes	No
Cancer	Yes	No
YOUR ALLERGIES & IMMUNE SYSTEM		
Inhalant (nasal) Allergies	Yes	No
Immunological Disorders	Yes	No
YOUR FEELINGS		
Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder	Yes	No
Treatment: _________________		

I believe that my answers are correct	I have reviewed the above information with the patient
Sign your name and put today's date and time	Physician's Name Date Time
	Physician's Signature

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GENERAL

HEENT ❑ NC/AT ❑ PERRL ❑ EOM-I ❑ Oropharynx clear ❑ Dentures

Neck ❑ Supple non tender no lymphadenopathy ❑ FAROM ❑ Spurling's sign ❑ Adson Manuever

Chest/ Lungs ❑ CTA bilateral ❑ rales ❑ rhonchi ❑ diminished breath sounds

Cardiovascular ❑RRR nl S1, S2 murmur Y N

Extremities

Shoulder ROM

	R	L
FF		
ABD		
ER		
IR		
ABD-IR		
ABD-ER		

Shoulder Strength

	R	L
ER		
ABD		
IR		

❑ + Belly Press Test

Impingement: ❑ Hawkins ❑ Neers ❑ Crepitance ROM

Bicep:
❑ TTP Bicipital Groove
❑ O'Brien's Sign
❑ Speeds Exam

Scapula:
❑ Winging
❑ Dyskinesia

Instability:
❑Apprehension
❑Relocation
❑ Ant/Post Drawer
❑ Ant/Post Load & Shift Exam
❑ Jerk Test

AC Joint:
❑ TTP AC Joint
❑ Deformity Clavicle
❑ Scarf
❑ Cross Arm Adduction

Beightons Score:
❑Elbow Hyperext
❑ Knee Hyperext
❑ Thumb/Forearm Appostion
❑ Palms on Floor

Elbow ROM

	R	L
Flex		
Ext		
Pron		
Sup		

Elbow Strength

	R	L
Flex		
Ext		

TTP: ❑Lat Epicondyle ❑ Med Epicondyle ❑ Radial Head
❑Olecranon ❑ Biceps

Ulnar nerve: ❑Subluxation ❑ Tinel's ❑ Intrinsic atrophy
❑Decreased SLT Ulnar Fingers ❑ABD/ADD weakness
❑Flexion/Compression Test Elbow

Instability:
❑Moving Valgus Stress Test ❑Milking Manuever
❑Varus Align ❑ + Varus Stress Test ❑ + Valgus Stress Test
❑Lateral Pivot Shift Test

Epicondylitis:
❑Pain Resisted Wrist Extension ❑Pain Resisted Finger Exten
❑ Pain Resisted Wrist Flexion

Skin: ❑ Intact ❑ Rash/ Lesions ❑Incisions/Scars _________ ❑ Atrophy ___________________

Neuro: ❑ II – XII intact ❑ Sensory exam intact ❑ 2+ BR/TRI/Bi Reflexes ❑ Abnormalities:

Radiology: X-rays:

MRI/MRA:

CT/CTA:

Impression:

Plan:

MD/ PA: _________________________________ **Signature:** ____ **Date:** _____________
Print name