CHATHAM ORTHOPAEDIC ASSOCIATES, P.A.

JOHN T. PRATHER, MD

** PLEASE FILL OUT COMPLETELY **
WE APPRECIATE YOUR TIME AND EFFORT SPENT COMPLETING THIS FORM

Patient Information

NAME	DATE OF BIRTH	AGE	SOCIAL SECURITY #
PRIMARY CARE PHYSICIAN		OFFICE LOCATION	
REFERRED BY		OFFICE LOCATION	

AFFILIATION: ☐ MEMORIAL ☐ ST.JOE / CANDLER ☐ SOUTHCOAST ☐ OTHER:

HAVE YOU SEEN DR. PRATHER BEFORE? ☐ NO ☐ YES; IF SO ☐ NEW PROBLEM ☐ SAME PROBLEM

IS THIS PROBLEM: ☐ WORK RELATED ☐ AUTOMOBILE ACCIDENT ☐ PERSONAL INJURY ☐ HAVE YOU FILED A CLAIM ☐ CONSIDERING FILING A CLAIM

HEIGHT	WEIGHT

LEFT

RIGHT

AGE	ARE YOU: ☐ RIGHT HANDED ☐ LEFT HANDED	SEX: ☐ MALE ☐ FEMALE
REASON FOR VISIT		DATE OF ONSET / ACCIDENT:

HOW DID THE PROBLEM START OR INJURY OCCUR

* What body part is involved?

☐ NECK	☐ LT SHOULDER	☐ LT ELBOW	☐ LT HAND	☐ LT PELVIS	☐ LT KNEE	☐ LT FOOT
	☐ RT SHOULDER	☐ RT ELBOW	☐ RT HAND	☐ RT PELVIS	☐ RT KNEE	☐ RT FOOT
☐ MID BACK	☐ LT ARM	☐ LT WRIST	☐ LT FINGER	☐ LT HIP	☐ LT ANKLE	☐ LT TOE
☐ LOWER BACK	☐ RT ARM	☐ RT WRIST	☐ RT FINGER	☐ RT HIP	☐ RT ANKLE	☐ RT TOE

HAVE YOU BEEN TREATED ELSEWHERE? ☐ NO ☐ YES	WHERE:	BY WHOM:
X-RAYS TAKEN: ☐ NO ☐ YES; WHEN: WHERE:	MRI OR CT SCAN: ☐ NO ☐ YES; WHEN: WHERE:	NERVE STUDIES: ☐ NO ☐ YES; WHEN: WHERE:

PREVIOUS INJURIES:
HAVE YOU HAD PRIOR PROBLEM WITH THIS SAME ORTHOPEDIC CONDITION IN THE PAST? ☐ NO ☐ YES;

IF YES, PLEASE EXPLAIN: _____

WHAT DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS PROBLEM:

☐ X-RAYS	☐ BONE SCAN	☐ MYELOGRAM	☐ MRI
☐ EMG/NCS	☐ DEXA SCAN	☐ CT SCAN	☐ OTHER: _____

Please check the box below which nest describes your problem:"

*The pain is ☐ CONSTANT ☐ COMES AND GOES (INTERMITTENT)

*SEVERITY OF PAIN ☐ MILD ☐ MODERATE ☐ SEVERE ☐ EXTREMELY SEVERE

*WHAT IS THE QUALITY OF PAIN? ☐ SHARP ☐ DULL ☐ STABBING ☐ THROBBING ☐ ACHING ☐ BURNING ☐ OTHER: _____

ARE THERE ASSOCIATED SYMPTOMS? ☐ SWELLING ☐ NUMBNESS ☐ WEAKNESS

SINCE MY PROBLEM STARTED, IT IS: ☐ GETTING BETTER ☐ GETTING WORSE ☐ UNCHANGED

DOES YOUR PAIN WAKE YOU FROM SLEEP? ☐ YES ☐ NO

WHAT MAKES YOUR SYMPTOMS WORSE? ☐ ACTIVITY ☐ EXERCISE ☐ WORK ☐ OTHER: _____

WHAT MAKE YOU FEEL BETTER? ☐ REST ☐ HEAT ☐ ICE ☐ ELEVATION ☐ OTHER: _____

DO YOU HAVE ANY ONE OF THE FOLLOWING? ☐ FEVER ☐ CHILLS ☐ SWEATS

DO YOU HAVE DIFFICULTY IN CONTROLLING BOWELS OR BLADDER? ☐ YES ☐ NO

CHECK WHICH TREATMENTS YOU HAVE TRIED FOR TODAY'S PROBLEM:

☐ INJECTION ☐ BRACE ☐ THERAPY ☐ CANE/CRUTCH ☐ CHIROPRACTOR ☐ ORTHOTICS ☐ OTHER: _____

Medical History

**** PLEASE MARK ALL CURRENT AS WELL AS PREVIOUS ILLNESSES ****

☐ AIDS/HIV	☐ BLEEDING PROBLEMS	☐ COPD	☐ STROKE
☐ MIGRAINES	☐ EMPHYSEMA/ASTHMA	☐ HEPATITIS A, B, C	☐ POLO
☐ ANEMIA	☐ FIBROMYALGIA	☐ OSTOEPOROSIS	☐ STOMACH PROBLEMS (ULCERS, REFLUX)
☐ ARTHRITIS	☐ HEART PROBLEMS	☐ NERVE PROBLEMS	☐ THYROID PROBLEMS
☐ DIABETES	☐ KIDNEY PROBLEMS	☐ PNEUMONIA	☐ BLOOD CLOTS (DVT, PE)
☐ EPILEPSY	☐ HIGH BLOOD PRESSURE	☐ PSYCHIATRIC DISORDERS	☐ RHEUMATOID ARTHRITIS
☐ GOUT	☐ MUSCLE DISEASE	☐ DEPRESSION/ANXIETY	

CANCER (TYPE):

☐ BREAST ☐ PROSTATE ☐ LUNG ☐ THYROID ☐ MYELOMA ☐ OTHER: _____ ☐**NONE**

PLEASE LIST ALL CURRENT MEDICATIONS, SUPPLEMENTS & HERBAL REMEDIES:

☐**NONE**

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ NO ☐ YES;
PLEASE LIST:
ARE YOU ALLERGIC TO LATEX? ☐ NO ☐ YES
HAVE YOU EVER HAD A REACTION TO ANESTHESIA? ☐ NO ☐ YES

ANY BLOOD THINNERS? ASPIRIN PLAVIX COUMADIN NSAIDS OTHERS

PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:

☐**NONE**

FALLS IN LAST YEAR? ☐ YES ☐ NO

EXPLAIN: _____

ARE THERE ANY ILLNESSES THAT RUN IN YOUR FAMILY? ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ ARTHRITIS
☐ CANCER (TYPE): _____

**** PLEASE MARK ALL CURRENT OR PREVIOUS SYMPTOMS ****

☐ CHEST PAIN	☐ CONSTIPATION	☐ ABNORMAL BLEEDING	☐ ABNORMAL MENSTRUAL CYCLE
☐ COUGH	☐ COLD HANDS/FEET	☐ GROWTH DISTURBANCE	☐ INCONTINENCE OF BOWEL
☐ DEPRESSION	☐ LOSS OF APPETITE	☐ RUNNING NOSE	☐ INCONTINENCE OF URINE
☐ EAR PAIN	☐ MUSCLE WEAKNESS	☐ NUMBNESS OF FEET	☐ SLEEP DISTURBANCE
☐ FAINTING	☐ IMPOTENCE	☐ NUMBNESS OF HANDS	☐ SPUTUM PRODUCTION
☐ FEVER	☐ BALANCE PROBLEMS	☐ SHORTNESS OF BREATH	☐ VISUAL DISTURBANCE
☐ MANIA	☐ SEIZURES	☐ SORE THROAT	☐ SWELLING IN LEGS
☐ SKIN RASH	☐ SKIN ULCERS	☐ WHEEZING	☐ UNE**XPLAINED WEIGHT LOSS**
☐ VOMITING	☐ STOMACH PAIN	☐ WEIGHT GAIN	☐ OTHER: _____

ARE YOU INDEPENDENT IN NORMAL DAILY ACTIVITIES? ☐ NO ☐ YES HAS THIS CHANGED RECENTLY? ☐ NO ☐ YES

PATIENT SIGNATURE	DATE	PHYSICIAN SIGNATURE	DATE