**University Orthopedic and Joint Replacement Center**
**Richard D. Berkowitz, M.D., FAAOS**
**7171 North University Drive, Suite 100, Tamarac, FL 33321**
**Telephone: (954) 718-7776 Facsimile: (954) 597-7773**

Name:_____ Date:_____

PCP: _____ Age: _____

Insurance:_____

## DO NOT WRITE BELOW "FOR OFFICIAL USE ONLY"

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- ☐ Right ☐ Left ☐ Bilateral
- ☐ L-Spine (2)
- ☐ Pelvis ☐ Pelvis (Stand)
- ☐ Hip ☐ Femur ☐ Knee (1) ☐ Knee (2) ☐ Knee (3) ☐ Knee (4) ☐ Tibia
- ☐ Other

Pregnant ☐ Yes ☐ No Shielded ☐ Yes ☐ No Tech_____ Patient_____

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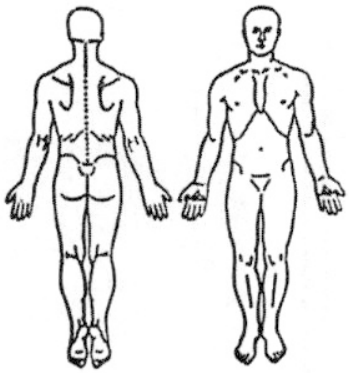
**Patient Name:** _____

**Chief Complaint:**
Why are you seeing the doctor today?_____
My problem began on:_____
Type of Injury: ☐ Work accident ☐ Sports ☐ Car accident ☐Slip and fall ☐ Other:____
Were you seen in an Emergency Room: ☐ No ☐ Yes
Where:_____ When:_____

**Orthopedic Review of Systems:** ☐None

Location of Pain: ☐ Back ☐ Neck ☐ Hip ☐ Knee ☐ Ankle ☐ Shoulder ☐ Wrist ☐ Elbow ☐ Hand
Describe Pain: ☐ Occasionally ☐ Constantly ☐ Daily ☐ With Motion ☐ Wakes from Sleep ☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Toothache ☐ Radiating ☐ Vague
I Have: ☐ Locking ☐Giving Way ☐ Joint Warmth ☐ Joint Stiffness ☐ Loss of Motion
Pain Occurs: ☐ Morning ☐ Afternoon ☐ Evening ☐ With Exercise
Difficulty: ☐ Sitting ☐ Tying Shoes ☐ Sleeping on Side ☐ Raising Arm ☐ Standing ☐ Climbing Stairs ☐ Walking ☐ Getting out of Chair

Left Right Right Left



Mark Injured Area

**Prior Treatment of Your Current Problem**
Have you been seen by another doctor within the last year for this problem: ☐ No ☐ Yes
How long has this problem been going on:_____
When did the problem become severe:_____
Have you had Physical Therapy: ☐ No ☐ Yes – Where:_____
Have you tried medications: ☐ No ☐ Yes – Which ones:_____
Do you have a problem with taking anti-inflammatory medication (Advil/Aleve): ☐ No ☐ Yes
Have you had cortisone / steroid injections: ☐ No ☐ Yes – How many:_____
If its your knee, have you had "Jelly" injections: ☐ No ☐ Yes –Which one:_____
Do you use a cane or a walker: ☐ No ☐ Yes For how long:_____
Has your leg given out or have you fallen: ☐ No ☐ Yes
Does the pain wake you at night: ☐ No ☐ Yes
Does the pain/disability limit your ability to perform your activities of daily living: ☐ No ☐ Yes
Can you walk more than one block: ☐ No ☐ Yes

**Diagnostic Testing:** (Test already performed elsewhere)
☐ X-rays ☐ MRI ☐ CT Scan ☐ Nerve Test ☐ Bone Scan ☐ Bone Density Scan ☐ Blood Work

Patient Signature:_____ Date:_____
Reviewed by:_____M.D. Date:_____

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**Height**: _____Ft_____Inches **Weight:**_____ lbs

**Past Medical History:** ☐ None

☐ Asthma ☐ Sleep Apnea ☐ Bleeding Disorder ☐ Blood Clot ☐ Diabetes
☐ Lung Disease ☐ Colitis ☐ Ulcers ☐ Stroke ☐ Heart Disease ☐ Hepatitis
☐ Glaucoma ☐ Nerve Disease ☐Arthritis ☐ Migraines ☐ High Cholesterol
☐ HIV/AIDS ☐ Gout ☐ Kidney Disease ☐ Cataracts ☐ Fractures ☐ Diverticulosis
☐ Osteoporosis ☐ High Blood Pressure ☐ Tuberculosis ☐ Prostate Enlargement
☐ Cancer (type)_____
☐ Other:_____
☐ Other:_____

**Past Surgical History:** ☐ None

☐ Appendectomy ☐ Gall Bladder ☐ Breast ☐ Hernia ☐ Stomach/Colon ☐ Cataract
☐ Heart Bypass ☐ Heart Valve ☐ Pacemaker ☐ Back/Neck ☐ Tonsillectomy
☐ Hand ☐ Hysterectomy ☐ C-Section ☐ Prostate ☐ Skin Cancer
☐ Cancer (Location)_____ ☐ Other:_____
☐ Joint Replacement (Location)_____
☐ Arthroscopy (Location)_____

**General Review of Systems:** ☐ None

Check all that Apply to this Visit
☐ Fever ☐ Chills ☐ Weight Loss ☐ Weight Gain ☐ Nausea ☐ Loose Teeth
☐ Constipation ☐ Glaucoma ☐ Glasses/Contacts ☐ Visual Disturbance ☐ Rash
☐ Vomiting ☐ Depression ☐ Dentures ☐ Leg Cramps ☐ Ringing in Ears
☐ Night Sweats ☐ Chest Pain ☐ Bleeding ☐ Swelling ☐ Palpitations ☐ Diarrhea
☐ Pain Urinating ☐ Difficulty Urinating ☐ Cough ☐ Fatigue ☐ Hearing Loss
☐ Shortness of Breath ☐ Anxiety ☐ Insomnia ☐ Numbness ☐ Tingling
☐ Blood in Urine ☐ Incontinence ☐ Memory Loss ☐ Dizziness ☐ Nocturia
☐ Headache ☐ Easy Bruising ☐ Skin Lesions ☐ Cataracts ☐ Swollen Glands
☐ Sore Throat

Patient Name: _____
Patient Signature:_____ Date:_____
Reviewed by:_____M.D. Date:_____