Sarah Bush Lincoln
Bonutti Clinic

BONUTTI CLINIC
HISTORY OF INJURY / COMPLAINT

THIS FORM MUST BE FILLED OUT COMPLETELY BEFORE SEEING THE DOCTOR. THANK YOU.

PATIENT NAME: ____________________ DATE: ____________ DOB: ____________

AGE: ____________ MARITAL STATUS: ____________ HAND DOMINANCE: RIGHT / LEFT (Please Circle)

LANGUAGE: ____________ RACE: ____________ ETHNICITY: ____________

PHYSICIAN SEEING TODAY AT BONUTTI CLINIC: ____________ REFERRING PHYSICIAN: ____________

EMERGENCY ROOM VISIT / LOCATION: ____________ DATE OF INJURY: ____________ LENGTH TIME PRESENT: ____________

LOCATION OF PROBLEM: ____________

HOW / WHAT HAPPENED? ____________

____

WHAT MAKES YOUR PROBLEM WORSE? ____________

WHAT MAKES YOUR PROBLEM BETTER? ____________

EMPLOYER NAME: ____________ YEARS EMPLOYED: ____________ WORK COMP: YES / NO

JOB TITLE / TYPE OF WORK YOU PERFORM: ____________

I hereby represent and acknowledge that all information provided herein is accurate and complete.

Patient Signature: ____________ Date: ____________ Time: ________

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*****BELOW SECTION TO BE COMPLETED BY OFFICE STAFF ONLY*****

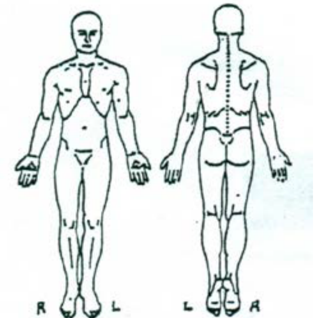
WHERE DID INJURY OCCUR? ____________

PRIOR TREATMENT: (√ which apply) Medication [ ] X-ray [ ] MRI [ ] Injection [ ] Physical Therapy [ ]

IF YOU ARE HAVING PAIN, RATE THE PAIN ACCORDING TO THE SCALE BELOW: (please circle)

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10
No Pain **Severe Pain**

Circle Where You Have Pain / Problem



Circle those that apply under each category

Location	**Quality**	**Duration**	**Associated Symptoms**	**Timing (when occurs)**
generalized	sharp	intermittent	bruising	at rest / sitting
localized	dull	constant	numbness / tingling	with activity
radiating site	stabbing		locking	at night / sleeping
	throbbing		swelling	other ____________
	burning		none	
	aching			

	Yes	No
Do You Use Alcoholic Beverages?	[ ]	[ ]
Are You Pregnant?	[ ]	[ ]
Do You Have Diabetes?	[ ]	[ ]
Do You Smoke?	[ ]	[ ]

_______ packs per day for _______ years

	Yes	No
Do You Have Heart Disease?	[ ]	[ ]
Have you seen a cardiologist?	[ ]	[ ]

If **YES**, Cardiologist's Name: ____________

Please circle those below that apply:

Stents Heart Attack Stroke Atrial Fib Heart Arrhythmia

Any other heart problems: ____________

ALLERGIES: (List drug and/or other allergies with associated reaction) If none, please √ box ☐

____

MEDICAL HISTORY: (List medical conditions) ____________

SURGICAL HISTORY:(List any previous surgeries/hospitalizations) ____________

FAMILY HISTORY: (List pertinent family history) ____________

****THIS SIDE TO BE COMPLETED BY OFFICE STAFF ONLY****

NAME ________________ **DOB** __________ **DR.** ________________ **DATE** __________

CARRIER ________________________________ **Date Of OR / Injury** ______________

CC ____

Vitals: Height: ____________ **Weight:** ____________ **BP:** ______________

Exam √ = Assessed

Const: ☐ well-developed ☐ well-nourished ☐ no acute distress ☐vital signs

Eyes: ☐ Pupils Equal ☐ Sclera clear & white ☐ No petechia or jaundice

Lymph: ☐ No lymphedema

Card: ☐ Blood pressure ☐ Respirations - Not labored, No wheezing

Skin: ☐ No rashes, lesions or ulcers ☐ Warm & dry, normal turgor

Neuro/Psych: ☐ Alert oriented X 3 ☐ Normal mood

Musculo/Extrem: ☐ No atrophy or weakness ☐ No edema

☐ Other ____

Diagnostic Testing **XRAY / MRI / CT**

Today or Date __________ **Yes** ____ **No** _____

Of: ________________________________

# of Views: ________________________________

Findings:

HPI / Reason for Visit ____

Exam ____

ROM ______________________________

Incision: ☐ Well approximated ☐ Well healed ☐ Skin intact ______________________

Gait: ☐ Normal ☐ Antalgic ☐ Flexed ☐ Stiff ☐ Shortened ☐ Other ______________________

Assistive Device: ☐ None ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ______________________

Difficulty with Stairs: ☐ No Difficulty ☐ Ascending Stairs ☐ Descending Stairs ☐ Both ascending / descending stairs ______________

DX____

Treatment / Follow-up______________________________

Physician Signature ________________________________ **Nurse Initials** ____________ **Note Dictated [ ]**