ASHEVILLE ORTHOPAEDIC ASSOCIATES
AN AFFILIATE OF MISSION HEALTH

Asheville Orthopaedic Associates Symptom Sheet

Patient's Name: _____Date:_____ Account #:_____

Date of Birth: _____ Height: _____ Weight: _____ Pharmacy: _____

Location: _____

Primary Care Physician: _____ Marital Status: *Married* *Widowed* *Single* *Divorced*

Reason for today's visit: _____

Circle all that apply: *Burning* *Numbness* *Tingling* *Swelling* *Aching* *Pain* *Triggering* *Mass*

Did your pain/symptoms occur after an accident? Y or N

If yes, circle all that apply: *Motor vehicle accident* *Work accident* *Other:*_____

Date of Accident/Injury: _____ How Accident/Injury happened: _____

Are you involved in a lawsuit in regards to this injury? Y or N Lawyer: _____

Are you filing a disability claim in regards to this injury? Y or N

Have you had any studies/procedures for this problem?

Circle all that apply: *MRI* *X-ray* *NCS/EMG* *Injections* *Other:* _____

When was your last:

Flu Shot: _____

Pneumovax: _____

Mammogram (if applicable): _____

Colonoscopy: _____

Drug allergies/Reaction:

_____

_____

_____

_____

Surgical History:

_____YEAR_____COMPLICATIONS_____

_____YEAR_____COMPLICATIONS_____

_____YEAR_____COMPLICATIONS_____

_____YEAR_____COMPLICATIONS_____

Current Medications: (Please list the reason you take the medication on the line adjacent to the dosage)

1. _____DOSAGE_____
2. _____DOSAGE_____
3. _____DOSAGE_____
4. _____DOSAGE_____
5. _____DOSAGE_____

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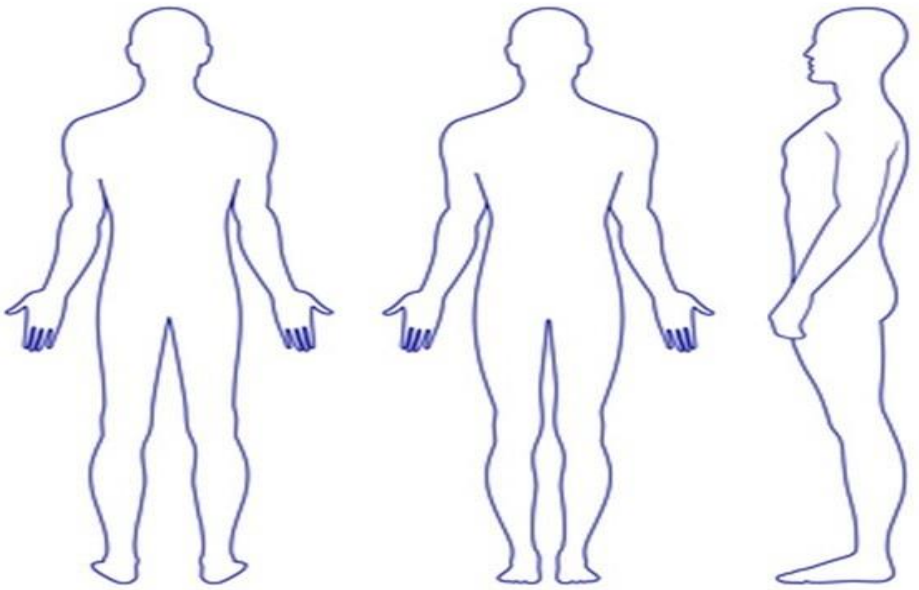
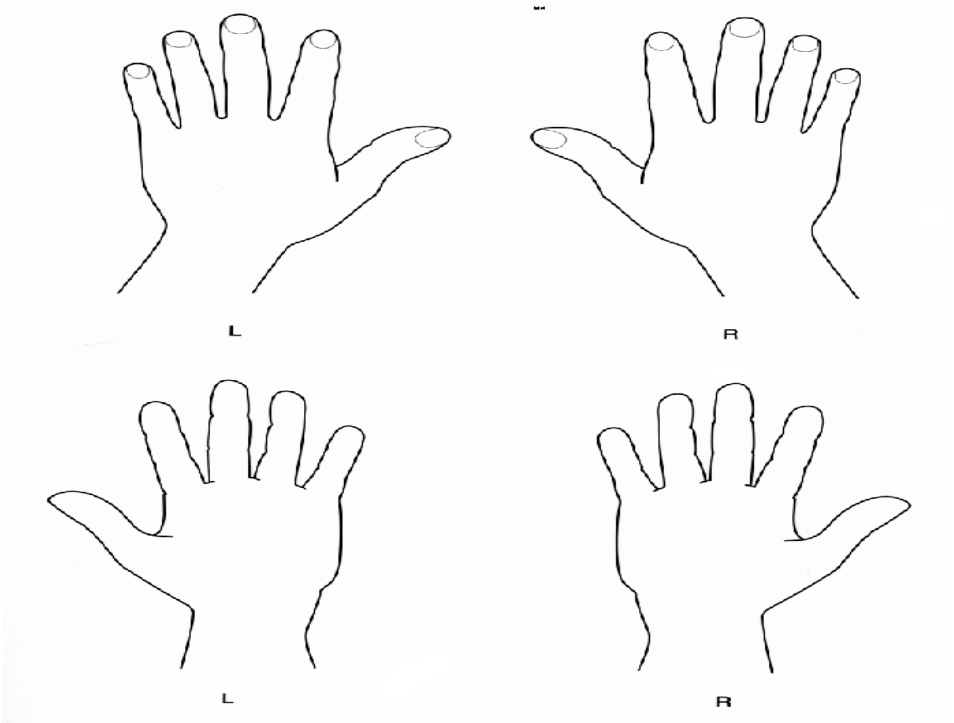
6. _____DOSAGE_____
7. _____DOSAGE_____
8. _____DOSAGE_____
9. _____DOSAGE_____
10. _____DOSAGE_____

Past Medical History:

1._____
2._____
3._____
4._____
5. _____
6._____
7._____
8._____
9._____
10. _____



Please indicate the level and location of pain on the following two diagrams (Indicate with an "X" on the picture)



Level of Pain:

- ☐ 10 HIGH
- ☐ 9
- ☐ 8
- ☐ 7
- ☐ 6
- ☐ 5
- ☐ 4
- ☐ 3
- ☐ 2
- ☐ 1 LOW

OFFICE USE ONLY:

Physician Signature _____ Date: _____