Orthopaedic **A**nd **S**ports **I**njury **S**ervices

Please indicate any of the following conditions that <u>you</u> have:

	Yes	No		Yes	No		Yes	No
Arthritis			Asthma			Vision difficulties		
Diabetes			Bronchitis			Swallowing difficulties		
Thyroid Condition			Other respiratory condition			Slurred speech		
Dizziness/fainting			Hearing impairment			Memory problems		
Low/high blood pressure			Pregnancy			Balance problems		
Heart condition			Metal implants (inc IUD)			Recent falls/blackouts		
Chest pain			Hernia			Unexplained weight loss		
Pacemaker			Depression			Groin numbness/tingling		
History of cancer			Osteoporosis			Bowel/bladder difficulties		
Allergies to tape/latex			Smoking history			Headaches		
Any allergies			Raynaud's			Blood disease		
Epilepsy/seizures			Sleeping problems			Other:		
Shortness of breath			Cough					

Surgeries: (with approx. dates) _____
Previous injuries (with approx. dates)_____
Injections (with approx.. dates_____

Do you sleep through the night? Yes No
Do you wake but feel unrested? Yes No
What position do you sleep in? Lying on: Back Front Side

Is there anything else we should know about your health? _____

Do you have a return appointment with the doctor who assessed you? Yes No

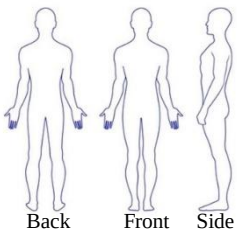
What areas of your daily life do you find are most affected by the concern you are here to have addressed?
_____

Please list any medications (with dosages) you are currently taking:
If you have a list, we are happy to make a copy for you
_____

Have you had any of the following for the condition for which you are currently referred?

X-rays	Yes	No	CT scan	Yes	No
EMG/nerve conduction	Yes	No	MRI	Yes	No
Bone density study	Yes	No	Ultrasound	Yes	No

Other:_____



Please indicate with an X your main area(s) of concern for today's assessment

Consent to assessment and treatment:

_____ _____
Signature Date