CAROLINA ORTHOPAEDIC SPECIALISTS, PA

This form is to assist you and Dr. Stanislaw in providing you the best care possible for your problem. Please answer the following questions to the best of your ability.

Patient Name:_____

Patient's date of birth: _____

What body part are we seeing you for today? _____

- Was this what your appointment was made for? Yes No

Have you had any x-rays or tests done concerning your problem? Yes No

Where (name of doctor or hospital)? _____

What was the date of injury or how long have you been hurting? _____

Please rate your pain: (please circle one) 1 2 3 4 5 6 7 8 9 10

Describe your pain:

1. Sharp
2. Shooting
3. Stabbing
4. Throbbing
5. Radiating
6. Other/None

Have you or are you currently taking medication for this problem? If yes, please list,

_____

Who referred you to this office? _____