

Office Use Only: Account # _____ Date: _____
Height: _____ Weight: _____ BP: _____ Pulse: _____ M.A. Initials: _____

Medical History Form (Please Print)

Patient Name: _____ Appointment Date: _____ with Dr. _____

DOB: _____ Age: _____ Sex: F M Dominant Hand: R L Did you bring x-rays? Y N

Primary Physician: Name _____ Street _____ City _____

State _____ Zip _____ Phone: _____ Referred by: Name: _____

Street _____ City _____ State _____ Zip _____ Phone _____

CHIEF COMPLAINT: What is the reason for this visit? Pain Numbness Weakness Swelling

Stiffness Other _____

What body part is involved? Please mark the table below or complete for other: _____

Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L	Neck <input type="checkbox"/> R <input type="checkbox"/> L	Back <input type="checkbox"/> R <input type="checkbox"/> L
---	--	--	---	--	---	--	---	---	---

HISTORY OF PRESENT ILLNESS: Date of Onset: _____ Or, how long ago did it start? _____ Days

Weeks _____ Months _____ Years _____ Have you had a problem like this before? Y N

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions regarding the box you checked (see COMMENTS).

NO INJURY (or onset was: Gradual or Sudden) Please indicate why do you think it started?

INJURY (Accident Sport (NOT Auto or Work) Date: _____ Please specify where and how it happened. What sport? _____ School? _____

INJURY AT WORK Date: _____ From a: lift twist fall bend pull reach

WORK RELATED (BUT NO INJURY) Date: _____ How did your job cause the problem?

AUTO ACCIDENT Date: _____ How was your car hit?

COMMENTS: _____

On a scale of 0 – 10 (10 is the worst), how severe is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is constant comes and goes (intermittent). Does your pain wake you from your sleep? Y N

Do you have: Swelling Bruises Numbness Tingling Weakness Loss of control of bowel or

bladder Locking/Catching Giving way Fever Chills Sweats Chest pain Shortness of breath

Since your problem started, it is: Getting better Getting worse Unchanged

What makes your symptoms worse? Standing Walking Lifting Exercise Twisting Lying in bed
Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

Which make your symptoms better? Rest Elevation Ice Heat Other _____

Have you had any of these treatments? Medications: Y N Which ones? _____

Injection: Y N Brace: Y N Physical Therapy: Y N Cane/Crutch: Y N

Were you seen in the E.R. for this problem: Y N Which E.R.? _____ Date: _____

Are you here today as a result of an E.R. visit? Y N Who saw you in E.R.? _____ MD PA

What tests have you had for this problem? X-rays MRI CAT Scan Bone Scan Nerve Test (EMG/NCV)

Where? _____ Date(s): _____

For other problems: Body Part(s): _____

Where? _____ Date(s): _____

Have you already had surgery for a problem in this same area either recently or in the past? N Y

List: Procedure #1 _____ Surgeon _____ City _____ Date _____

Procedure #2 _____ Surgeon _____ City _____ Date _____

Occupation: _____

Current work status? Regular Light duty – (how long? _____) Not working due to this problem

Disabled Retired Student When is the last date you worked your regular job? _____

Are you currently receiving / plan to apply for: Disability: Y N Workers' Comp: Y N Unemployment: Y N

MEDICAL HISTORY: **ALLERGIC TO ANY MEDICATIONS?** Y N If yes, please list and describe reaction: _____

Latex Allergy? Y N

Please turn over to complete other side.

MEDICAL HISTORY (Continued): **PATIENT NAME:** _____

LIST ALL MEDICATIONS YOU ARE TAKING NOW: _____

Are you diabetic? N Y If yes, treatment: Insulin Oral medications Diet None
Are you taking, or have you ever taken, blood thinners? N Y If yes, which one? _____
Have you ever had: Heart attack (year _____) High blood pressure Blood clots (year _____) Stroke
 Heart failure Ankle swelling Kidney failure Cancer (location _____)
 Stomachache while taking anti-inflammatory (includes Advil/Aleve). What anti-inflammatory have you already had a problem with? _____
 OTHER: _____

PAST SURGICAL HISTORY: What operations have you had and when? Please list: _____

Have you or a family member ever had a reaction to anesthesia? N Y Explain: _____

PAST HOSPITALIZATIONS: (Not for surgery): _____ None

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?
 Diabetes _____ High blood pressure _____ Rheumatoid arthritis _____
 None Do any direct relatives have the same condition you are being seen for today? Y N

SOCIAL HISTORY:
Do you use tobacco? N Y If yes, packs per day _____ **Patient informed of smoking risk?** Y
Alcohol use? N Y If yes, how often? Daily Other _____/week
Marital History: M S D W How many people live with you? _____
Occupation: _____ Employer: _____
Do you plan to be working six months from now? Y N Student? Y N
Have you had a prior problem with this same Orthopaedic condition in the past? N Y (Explain below)

Do your other joints have: morning stiffness lasting over 30 minutes joint pain or swelling back pain
 rheumatoid arthritis osteoporosis prior fracture (which bone) _____ None of these

REVIEW OF SYSTEMS:

Have you had any of these symptoms? If no, mark <u>None</u> .		None	Details / Other
1) GI	<input type="checkbox"/> Heartburn, ulcers <input type="checkbox"/> Nausea, vomiting <input type="checkbox"/> Blood in stool	<input type="checkbox"/>	_____
	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver disease		_____
2) ENDO	<input type="checkbox"/> Thyroid disease <input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/>	_____
3) CON	<input type="checkbox"/> Weight loss <input type="checkbox"/> Loss of appetite	<input type="checkbox"/>	_____
4) EYE	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Vision loss	<input type="checkbox"/>	_____
5) ENT	<input type="checkbox"/> Hearing loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Trouble swallowing	<input type="checkbox"/>	_____
6) CV	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations	<input type="checkbox"/>	_____
7) RS	<input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath	<input type="checkbox"/>	_____
8) GU	<input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney problems	<input type="checkbox"/>	_____
9) SK	<input type="checkbox"/> Frequent rashes <input type="checkbox"/> Skin ulcers <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis	<input type="checkbox"/>	_____
10) NEU	<input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures	<input type="checkbox"/>	_____
11) PSY	<input type="checkbox"/> Depression <input type="checkbox"/> Drugs/Alcohol Addiction <input type="checkbox"/> Sleep disorder	<input type="checkbox"/>	_____
12) HEM	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia	<input type="checkbox"/>	_____
13) ARE YOU HIV POSITIVE:	<input type="checkbox"/> N <input type="checkbox"/> Y		

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

Signature _____ Date _____