

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
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**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 \_\_\_\_\_