ORTHOPAEDIC SPECIALTIES

Medical History

Patient Name: _____

Patient - DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Primary Care Doctor Name: _____ **Primary Care Phone:** _____

Chief Complaint - (REASON YOU ARE HERE TODAY): _____

Date of Injury: _____ **How long have you had the problem?** _____

Where did it occur? ☐AUTO ☐WORK ☐SCHOOL ☐HOME ☐OTHER: _____

Were YOU Treated in the ER? ☐ NO ☐YES: WHICH HOSPITAL? _____ DATE _____

How Did You Hear About Us? (i.e. Other Doctor Referral/Internet/Friend,etc..) _____

Are you *RIGHT* or *LEFT* handed: **R** **L** (circle one) **OCCUPATION:** _____

MARK THE AREAS WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. INCLUDE ALL AFFECTED AREAS. MARK THE POINT OF MAXIMUM PAIN WITH A LARGE "X"

Sensation Symbols:

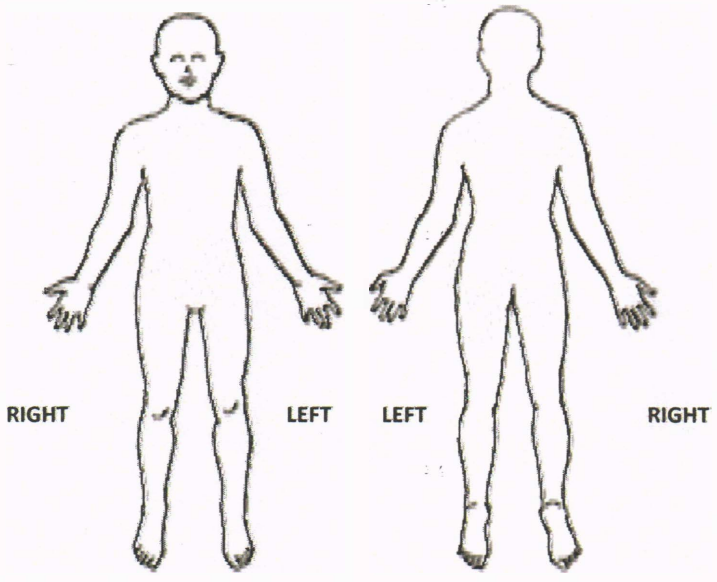
Ache = ^^^
^ ^ ^

Burning = x x x x
x x x x

Numbness = oooo
oooo

Pins & Needles: = = = =
= = = =

Stabbing = ////
////



What makes the pain WORSE? _____

What makes the pain BETTER? _____

MY PAIN IS WORSE IN THE ☐ **MORNING** ☐ **AT THE END OF THE DAY** ☐**ALL THE TIME**

SEVERITY OF PAIN

Please identify how much pain you experience <u>while resting:</u> **(Scale of 0 to 10)**

("0" Being No Pain – "10" being Worst Imaginable) 0..... 5..... 10

Please identify how much pain you experience <u>during activity:</u> **(Scale of 0 to 10)**

("0" Being No Pain – "10" being Worst Imaginable) 0..... 5..... 10

MRN: _____ Dr. Signature: _____ DOS: _____

PAST MEDICAL HISTORY

Patient Name: _____

REVIEW OF SYSTEMS: ***DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING***
(Please check-off Yes or No)

Yes	No	
		Metal Allergy
		Seasonal Allergy
		Cancer
		Type of Cancer:
		Fever
		Chills
		Excessive Weight Loss
		Excessive Weight Gain
		Night Sweats
		Eczema
		Psoriasis
		Rash
		Skin Lesions
		Chest Pain
		Heart Attack (MI)
		Congestive Heart Failure
		Irregular Heart Beat
		Pacemaker
		Hypertension
		Coronary artery disease
		Abdominal Pain
		Vomiting
		Ulcerative Colitis
		Hiatal Hernia
		Crohn's Disease.
		GERD
		Heartburn
		Asthma
		COPD/Emphysema
		Shortness of Breath
		Swollen Glands
		Easy bruising
		Blood Clots

Yes	No	
		Anemia
		Frequent Nose Bleeds
		Teeth Problems
		Dentures
		Loss of bowel or bladder function
		Saddle anesthesia
		Muscle Aches
		Muscle Weakness
		Swelling in Extremities
		Rheumatoid Arthritis
		Paralysis
		Seizures
		Stroke/TIA
		Tremors
		Parkinson's
		Thyroid Disorder
		Diabetes
		High Cholesterol
		Depression
		Bipolar
		Schizophrenia
		Anxiety Disorder
		Tuberculosis
		HIV/AIDS
		Hepatitis
		Polio
		MRSA
		Recent Travel Outside USA
		Where:
		Other:

PAST SURGICAL HISTORY: _____

_____

_____

_____

Dr. Signature: _____ **Date:** _____

Patient Name: _____

Pharmacy: Name: _____ **Phone:** _____

Pharmacy Location: _____

PATIENT SSN : _____-_____-_____

DAILY MEDICATIONS:

NAME OF DRUG - DOSAGE - HOW OFTEN TAKEN

1. _____ 9. _____
2. _____ 10. _____
3. _____ 11. _____
4. _____ 12. _____
5. _____ 13. _____
6. _____ 14. _____
7. _____ 15. _____
8. _____ 16. _____

Are you on blood thinners? Circle one: YES / NO DRUG: _____

DRUG ALLERGIES: **NAME OF DRUG** **PLEASE DESCRIBE THE REACTION**

_____
_____
_____
_____
_____

FOOD OR METAL ALLERGIES: _____

PREVIOUS TESTS & TREATMENTS FOR PROBLEM YOU ARE BEING SEEN FOR TODAY:

☐**XRAYS** (Date/Location) _____ ☐**MRI** (Date/Location) _____

☐**MYELOGRAM**(Date/Location)_____ ☐**CT SCAN** (Date/Location) _____

☐**BONE SCAN** (Date/Location) _____ ☐**PET SCAN** (Date/Location) _____

MEDICATIONS FOR THIS PROBLEM: ***CURRENT:*** _____

☐**INJECTIONS** (Type) _____ ☐**PHYSICAL THERAPY:** (Date/Location) _____

☐**HOME EXCERCISE** ☐ **MASSAGE** ☐**CHIROPRACTIC** ☐**OTHER :** _____

Dr. Signature: _____ **Date:** _____