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Medical Information

Form must be filled out before you see the physician. The information on the form provides basic information about your orthopedic problem and general health condition. This information is very important and can influence your orthopedic diagnosis and treatment.

Today's Date: _____ Patient Acct. #: _____

Name: _____ Sex: _____ Date of Birth: ____/____/_____ Age: _____

Height: _____ Weight: _____ Occupation: _____

Primary Care Doctor (Name/Phone #): _____

Are you seeing any Specialists? [ ] Cardiologist [ ] Rheumatologist [ ] Endocrinologist [ ] Neurologist [ ] Oncologist [ ] Pulmonologist [ ] Other

(Name/Phone # of specialist): _____

What type of orthopedic problem(s) are you being seen for today? _____

Did your symptoms result due to trauma/injury? [ ] Yes [ ] No If Yes, list date and nature of accident below.

_____

If <u>not</u> an accident, when did you first notice your problem? _____

Have you seen a doctor for this problem before? [ ] Yes [ ] No

How would you describe your symptoms (check all that apply)

[ ] Dull ache [ ] Sharp [ ] Stabbing [ ] Hot [ ] Cold [ ] Chills [ ] Numb [ ] Stiffness [ ] Cramping [ ] "Giving out" [ ] Weak [ ] "Sleepy" [ ] Tingling [ ] Cracking

Rate your pain at its worst:

Has this been improving? [ ] Improving [ ] Getting worse [ ] Remaining unchanged

How frequent are the symptoms in this area?

[ ] Occasional – less than half the day
[ ] Intermittent – about half the day
[ ] Frequent – more than half the day
[ ] Constant – all day and every day

Previous treatments? _____

What makes the symptoms worse? _____

Have you had similar problems before? _____

Medical Information (cont.)

Name: _____ DOB: _____ Date: _____

Which medical tests or treatments have you received for this problem?
[ ] X-ray [ ] CT scan [ ] MRI [ ] Bone scan [ ] Blood tests [ ] Nerve tests (EMG) [ ] Joint injection
[ ] Other _____

List **ALL surgeries** you have had and the approximate date. (Example: hip replacement, 1999)
_____
_____

List **ALL allergies** and any reactions (including allergies to medications):
_____

List all medications you are currently taking:

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

What active or past medical conditions have you had? (Check all that apply)
[ ] Diabetes [ ] Rheumatoid arthritis [ ] COPD [ ] Heart attack [ ] Stroke [ ] Sleep apnea [ ] Cancer
[ ] AFIB [ ] Reflux [ ] Hypertension [ ] Anemia [ ] Asthma [ ] HIV/Aids [ ] DVT/Blood clot [ ] MRSA

List any other serious medical condition(s) that are not shown above: _____

Social History:
Tobacco [ ] Current smoker [ ] Former smoker [ ] Non-smoker
If current/ former smoker, how much & for how long? _____

Alcohol Did you have a drink containing alcohol in the past year? [ ] Yes [ ] No
If yes, how often? [ ] Daily [ ] Occasional (2-3 drinks/week) [ ] Socially

Recreation drugs [ ] Current user [ ] Former user [ ] Non-user
If current/former user, what kind, how much & for how long? _____

Do you exercise? [ ] Yes [ ] No List type and frequency: _____

Family Medical History:

Relative	Current age	(or age at death)	Current medical condition(s) (or cause of death)
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____

Has anyone in your family (mother/father/siblings) experienced any of these health conditions?

[ ] Problems with anesthesia [ ] Bleeding conditions [ ] Diabetes [ ] Osteoporosis

Review of Symptoms: (Please note any symptoms you may currently have.)

Name: _____ DOB: _____ Date: _____

Check any of these NEW problems that may apply to you:

[ ] Weakness/arms [ ] Weakness/legs

[ ] Difficulty w/balance [ ] Fevers [ ] Chills [ ] Sweats [ ] Loss of appetite [ ] Bladder problems

[ ] Constipation [ ] Bowel problems [ ] Unexpected wt. loss (more than 10 lbs.) [ ] Pain wakes me up

General: [ ] unexplained weight change [ ] fever [ ] fatigue

Skin: [ ] rashes [ ] skin sores

ENMT: [ ] sore throat [ ] ear pain [ ] dry eyes

Respiratory: [ ] recurrent cough [ ] excessive sputum [ ] wheezing [ ] shortness of breath [ ] sleep apnea

Cardiac: [ ] chest pain at rest or on exertion [ ] high or low blood pressure [ ] high cholesterol [ ] irregular heart rate/rhythm
[ ] swelling of both legs or ankles [ ] sleeping on two or more pillows [ ] leg cramps when walking [ ] cold feet
[ ] sores on feet or ankles [ ] blood clots in legs

Gastrointestinal: [ ] heartburn [ ] recurrent nausea or vomiting [ ] recurrent constipation or diarrhea
[ ] loss of bowel control [ ] abdominal pain

Urinary: [ ] frequent urination [ ] loss of bladder control [ ] decreased force of urinary stream

Musculoskeletal: [ ] back pain [ ] neck pain

Neurological: [ ] seizure or convulsions [ ] abnormal memory loss [ ] slurred speech [ ] tremors [ ] frequent or constant
[ ] numbness or tingling in a body part

Hematologic: [ ] anemia [ ] easy bruising or bleeding [ ] splenectomy [ ] leukemia

Endocrinology: [ ] excessive urination [ ] excessive sweating or thirst

Psychology: [ ] excessive nervousness [ ] anxiety [ ] depression [ ] insomnia

Patient Signature: _____ Initial Date: _____

Patient Signature: _____ Date of annual update: _____

***Office Use Only**

Reviewed by Doctor: _____

Date: _____