GAREY ORTHOPEDICS

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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: _______

Primary Care Doctor/Referring Doctor (Name/Phone #): ______________________________________________________________

Height: _________ Weight: _________ Occupation: ________________________________ Dominant Hand: [ ] Right [ ] Left

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

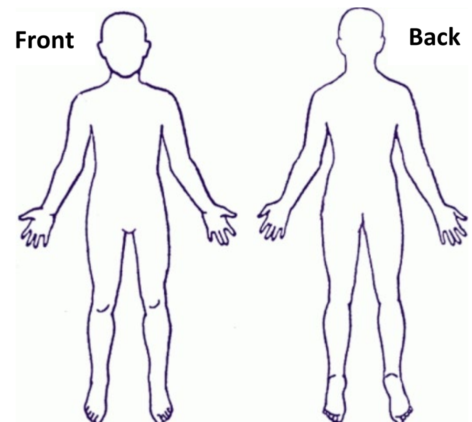
Did your symptoms result from an accident? [ ] Yes [ ] No If Yes, list date and nature of accident below.

___________________________________________________________________________________________________

If not an accident, when did your problem first occur? _____________________________________________________

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

Please rate your pain area on the diagram.




**Mark 1 for most painful**

**Mark 2 for next most painful**

**Mark 3 for third most painful**

**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

**Check the severity of your symptoms:**

[ ] Mild, no compromise of activities
[ ] Slight, some compromise of activities
[ ] Moderate, marked compromise of activities
[ ] Severe, unable to perform activities

**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

What relieves your symptoms? ______________________________________________________________________

What makes the symptoms worse? ___________________________________________________________________

Have you had similar problems before? _______________________________________________________________

## Medical Information (cont.)

**Name:** _______________________________________________ **Date:** ____________________________

Which medical tests or treatments have you received for this problem?
[ ] X-ray [ ] CT scan [ ] MRI [ ] Bone scan [ ] Blood tests [ ] Nerve tests (EMG) [ ] Myelogram
[ ] Nerve injection (nerve root block) [ ] Joint injection [ ] Discogram (X-ray of discs in back)
[ ] 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 <u>active</u> or <u>past</u> 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

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

| **Social History:** | Currently use | Previously used | How much | How long | Stopped |
|---|---|---|---|---|---|
| Tobacco | [ ] yes [ ]no | [ ]yes [ ]no | ________ | ________ | ________ |
| Beer, wine, liquor | [ ] yes [ ]no | [ ]yes [ ]no | ________ | ________ | ________ |
| Recreation/street drugs | [ ] yes [ ]no | [ ]yes [ ]no | ________ | ________ | ________ |

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 <u>currently</u> have.)

**Name:** ____________________________________________ **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

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***Office Use Only**

Reviewed by Doctor: ______________________________

Date: __________________________________