Health History - Orthopedics

Name: ______________________________ **DOB:** ______________
Preferred Name (Nickname): ______________________________
Pharmacy Name: ____________________ **Pharmacy Address:** ____________________
PCP/Referring Provider Name: ______________________________
List of all doctors you see (Care Team): ______________________________

Reason for today's visit: ______________________________
When did your symptoms begin? ______________________________
What triggers your symptoms? ______________________________
What makes your symptoms better? ______________________________
Grade your pain 0-10 (0= no pain and 10=worst pain): ______________________________
What treatment have you had for your symptoms? ______________________________
Affected Side: ☐ Left ☐ Right ☐ Both
Body Area: ☐ Knee ☐ Shoulder ☐ Hip ☐ Ankle ☐ Elbow ☐ Foot ☐ Hand ☐ Wrist ☐ Spine
☐Other: ______________________________

Is your problem getting: ☐ Worse ☐ Better ☐ Staying the same

What studies have you done? ☐ CT ☐ MRI ☐ Bone Scan ☐ Other_______

Have you had injections? ☐ Yes ☐ No

If so, where: ______________________________
How much did it help? ______________________________
For how long? ______________________________
Any additional complaints? ______________________________

Was this a result of an injury? ☐ Yes ☐ No

If yes, please complete the following questions:

What type of injury? ☐ Auto ☐ Worker's Compensation ☐ Other

Date of Injury: ____________________

Describe how it happened? ______________________________

If injured, is litigation ongoing? ☐ Yes ☐ No

Are you: ☐ Off Work ☐ Modified Duty ☐ Full Duty

ALLERGIES List all allergies to medications or foods and your reaction:

ALLERGY	REACTION

MEDICATIONS Please list all medicines you are currently taking (include over the counter such as vitamins):

NAME OF MEDICATION	DOSAGE	HOW OFTEN PER DAY

FAMILY HISTORY Please list any relative with the following medical problems and their relationship to you:

	Relation		Relation
☐ Blood Clot (Deep Vein Thrombosis)		☐ High Blood Pressure	
☐ Breast Cancer		☐ Osteoporosis	
☐ Colon Cancer		☐ Other Cancer	
☐ Depression		☐ Parkinson's Disease	
☐ Diabetes (Diabetes Mellitus)		☐ Rheumatoid Arthritis	
☐ Heart Attack		☐ Stroke	
☐ Heart Disease (Other than heart attack)		☐ Substance Abuse	

SOCIAL HISTORY

Tobacco Use	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long? _______________ Year Quit: ____________ ☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/day
Live alone or with others?	☐ Alone ☐ With others
Employment	Occupation: Employer:
Single or Multi-level home/work	☐ Single Level Home ☐ Multi-Level Home ☐ Single Level Work ☐ Multi-Level Work
Able to care for self ?	☐ Yes ☐ No
Hand dominance	☐ Right ☐ Left ☐ Bilateral
Sports Activities	
General Stress Level	☐ Low ☐ Medium ☐ High
Exercise Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Diet	☐ Regular ☐ Vegetarian ☐ Gluten Free ☐ Carbohydrate ☐ Cardiac ☐ Diabetic
Caffeine Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day _______________
Alcohol Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? _____
Is blood transfusion acceptable in an emergency?	☐ Yes ☐ No
Advance directive?	☐ Yes ☐ No

PAST SURGICAL HISTORY Have you ever had the following:

	Year		Year
☐ Amputation		☐ Fem Tib Bypass	
☐ Ankle/Foot Surgery		☐ Fracture Surgery	
☐ Arthroscopic Surgery		☐ Hand Surgery	
☐ Axillo-Fem Bypass		☐ Heart Surgery (Cardiac)	
☐ Back Surgery		☐ Joint Replacement	
☐ Bone Marrow		☐ Orthopedic Surgery	
☐ Cancer Surgery		☐ Popliteal Artery Stent	
☐ Carpal Tunnel Surgery		☐ Popliteal Balloon Angioplasty	
☐ Elbow Surgery		☐ Sinus Surgery	
☐ Fem Fem Bypass		☐ Spine Surgery (Cervical, Thoracic, Lumbar)	
☐ Fem Pop Bypass		☐ Other Surgeries:	

Any other Medical/Surgical history/conditions, please inform the nurse.

PAST MEDICAL HISTORY Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

	Yes	No		Yes	No
AFib (Atrial Fibrillation)	☐	☐	Hearing Loss	☐	☐
AIDS	☐	☐	Heart Attack (Myocardial Infarction)	☐	☐
Anemia	☐	☐	Heart Disease/Valve Disease	☐	☐
Anesthetic Complication	☐	☐	Heart Rhythm Problem (Palpitations)	☐	☐
Anxiety	☐	☐	High Blood Pressure (Hypertension)	☐	☐
Arthritis Osteoarthritis	☐	☐	High Cholesterol (Hyperlipidemia)	☐	☐
Arthritis Rheumatoid	☐	☐	HIV	☐	☐
Asthma	☐	☐	Implantable Pacemaker/Defibrillator/AICD	☐	☐
Back/Neck Pain	☐	☐	Kidney Disease/Stones	☐	☐
Bladder Problems	☐	☐	Liver Disease/Hepatitis	☐	☐
Bleeding Problems	☐	☐	Memory Loss (Dementia)	☐	☐
Blood Clot (Deep Vein Thrombosis)	☐	☐	Mental Illness (Bi-Polar Disorder, Schizophrenia)	☐	☐
CAD (Coronary Artery Disease)	☐	☐	MRSA (Antimicrobial Resistance)	☐	☐
Cancer	☐	☐	Multiple Sclerosis	☐	☐
Celiac Disease	☐	☐	Neuropathy (Numbness, Pain, Tingling)	☐	☐
CHF (Congestive Heart Failure)	☐	☐	Osteopenia/Osteoporosis	☐	☐
Chronic Pain Disorder	☐	☐	Parkinson's Disease	☐	☐
Claustrophobic	☐	☐	Prior Blood Transfusion	☐	☐
COPD (Chronic Obstructive Pulmonary Disease)	☐	☐	Pulmonary Embolism (Blood Clot in the Lung)	☐	☐
Depression	☐	☐	Rheumatic Fever	☐	☐
Developmental Disorder	☐	☐	Seizure Disorder	☐	☐
Diabetes (Insulin Dependent)	☐	☐	Sickle Cell Anemia	☐	☐
Diabetes (Non-Insulin Dependent)	☐	☐	Spine Disease (Herniated Disc, Scolosis, Stenosis)	☐	☐
Edema (Swelling)	☐	☐	Stroke/TIA	☐	☐
Eye Problems (Glaucoma, Retinopathy, Macular Degeneration)	☐	☐	Substance Abuse (Alcohol, Drug)	☐	☐
Fibromyalgia	☐	☐	Tuberculosis	☐	☐
Gastrointestinal Disease (IBS, Gastritis, Ulcer, Acid Reflux)	☐	☐	Other Disease(s):	☐	☐
Headaches/Migraines	☐	☐			