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Medical Information

Chart: _____

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. #: _____ Imaging: _____

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

Referring Doctor (Name/Phone #): _____

Height: _____ Weight: _____ Occupation: _____ Dominant Hand: R L

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

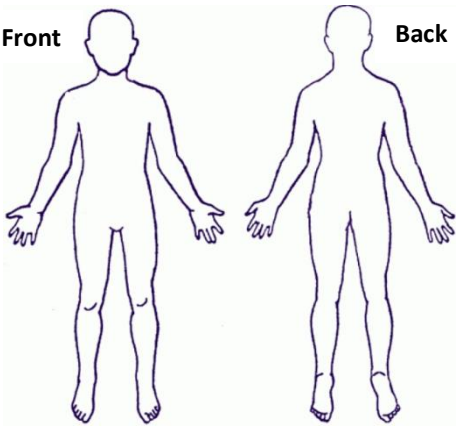
Did your symptoms result from an accident? [ ] Yes [ ] No If Yes, list date and nature of accident below.

_____

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 [ ] Moderate, marked compromise of activities
[ ] Slight, some 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 [ ] Frequent – more than half the day
[ ] Intermittent – about 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. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Use reverse side for additional medications.

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:	<u>Currently use</u>	<u>Previously used</u>	<u>How much</u>	<u>How long</u>	<u>Stopped</u>
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:

<u>Relative</u>	<u>Current age</u>	<u>(or age at death)</u>	<u>Current medical condition(s) (or cause of death)</u>
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

Reviewed: _____

Date: _____