Orthopedic Associates

Orthopedic Associates, LLC

Welcome to Orthopedic Associates. Please take time to complete this history form completely, even if you have previously completed a similar form. This will become part of your medical record. Thanks.

A.

1. Name:_____Date: _____
2. Phone Number: _____ Alternative Phone Number: _____
3. Family Doctor:_____Referred by: _____
4. Height:_____Weight:_____Birthdate:_____Age: _____ ❑ Right Handed ❑ Left Handed
5. **Chief Complaint:** *What are you being seen for today?* _____
6. Date of Onset: _____ . Is this problem due to an injury? ❑ Yes ❑ No
7. Have you had any previous problems with the same area? ❑ Yes ❑ No
8. Were you hurt at work? ❑ Yes ❑ No If yes, are your currently on: ❑ Full duty ❑ Light duty ❑ Off work
How long have you been on light duty or off work? _____
9. What started your problem or pain? _____
_____
_____
_____
_____

10. Treatments have included: ❑ No medications, therapy, injections, braces or casts.

- ❑ Physical therapy or exercise
- ❑ Massage or ultrasound
- ❑ Traction
- ❑ Manipulation/chiropractic
- ❑ Tens Unit
- ❑ Anti-inflammatory meds_____
- ❑ Narcotic meds_____
- ❑ Braces
- ❑ Cortisone injections, how many?_____
- ❑ Cast
- ❑ Name of last medication taken for this problem_____

11. Previous doctors seen for this problem: ❑ None

Doctor	Specialty	Date	Treatments

_____
_____

12. Tests done to evaluate your problem: ☐ None
Please list date of studies, results, and where study done if known.

- ☐ Plain X-rays _____
- ☐ EMG/NCV _____
- ☐ Other tests _____
- ☐ MRI/CT _____
- ☐ Bone scan _____

B. Medications *(Please list both prescription and non-prescription, including dose and frequency)*

_____
_____
_____
_____

C. Allergies *(list medications to which you are allergic or cannot take; please list nature of reaction)* ☐ None

_____
_____

D. Surgical History: *(Please list previous surgeries*) ☐ None

Operation	Surgeon	Date

_____
_____

Please print your name:_____

E. Medical History: *Do you have or have you had any of the following?*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	heart attack	☐	☐	heart failure	☐	☐	heart valve	☐	☐	high blood pressure
☐	☐	heart murmur	☐	☐	asthma	☐	☐	pacemaker	☐	☐	abnormal rhythm
☐	☐	COPD	☐	☐	emphysema	☐	☐	tuberculosis	☐	☐	diabetes
☐	☐	thyroid trouble	☐	☐	stroke	☐	☐	aneurysm	☐	☐	ulcers
☐	☐	reflux disease	☐	☐	liver trouble	☐	☐	hepatitis	☐	☐	kidney trouble
☐	☐	kidney stones	☐	☐	urinary problems	☐	☐	anemia	☐	☐	bleeding disorder
☐	☐	blood transfusion	☐	☐	blood clots	☐	☐	osteoarthritis	☐	☐	rheumatoid arthritis
☐	☐	osteoporosis	☐	☐	gout	☐	☐	depression	☐	☐	bipolar
☐	☐	schizophrenia	☐	☐	neuropathy	☐	☐	alcoholism	☐	☐	HIV/Aids
☐	☐	cancer	☐	☐	low back pain	☐	☐	serious injury	☐	☐	are you pregnant?

Please give details to those answered yes _____

_____

_____

_____

_____

F. Family History: *Please check any problems that run in your family.*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	heart attack	☐	☐	heart trouble	☐	☐	asthma	☐	☐	diabetes
☐	☐	stroke	☐	☐	aneurysm	☐	☐	gout	☐	☐	kidney trouble/stones
☐	☐	bleeding disorder	☐	☐	arthritis	☐	☐	alcoholism	☐	☐	mental illness
☐	☐	cancer—if yes what type? _____									

Other:_____

G. Social History

1. Work status: ❑ Working ❑ Unemployed ☐ Disabled ❑ Retired ☐ Homemaker

2. Occupation (current or most recent):_____

3. Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

4. Tobacco use: ☐ Never smoked ☐ Cigar ☐ Chew ☐ Pipe

- ☐ Cigarettes_____packs per day for _____years.
- ☐ Quit smoking_____years ago, after smoking_____packs per day for ____years

5. Alcohol: ☐ Never ☐ Rare ☐ Social (how much?_____) ☐ Alcoholic ☐ Recovering Alcoholic

6. Drug abuse: ☐ Never ☐ Currently ☐ In the past

H. Review of Systems: *Please circle any condition you are currently experiencing.*

Constitutional	Fever	Weight loss	Weight gain	Chills	Other _____
Neurologic	Headache	Dizziness	Memory Loss	Numbness	Other _____
Eyes	Glasses	Contacts	Double vision	Blurriness	Other _____
Ears/Throat	Deafness	Ringing	Hoarseness	Swallowing difficulty	Other _____
Cardiac	Chest pain	Skip beats	Rapid beat	Edema/ankle swelling	Other _____
Pulmonary	Cough	Cough blood	Short of breath	Wheezing	Other _____
Intestinal	Diarrhea	Bleeding	Incontinence	Constipation	Other _____
Urinary	Burning	Bleeding	Incontinence	Increased Frequency	Other _____
Musculoskeletal	Pain	Weakness	Arthritis	Joint Swelling	Cane/walker
Skin	Bruising	Lesions	Birth marks		Other _____
Hematologic	Bleeding	Transfusions	Hepatitis		Other _____
Psychiatric	Depression	Insomnia	Fatigued	Nervous exhaustion	Other _____
Miscellaneous	Metal implants		Claustrophobic		Other _____