Anderson Orthopaedic Clinic
Medical History Form—New Patient

Please thoroughly complete all 3 pages.

Patient Name: _____ **Appointment Date:**_____ **Age:** _____
Primary Care Physician?:_____ **Referring Physician?** _____

Did you bring x-rays? ☐Y ☐N

What is the reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other:_____

Dominant Hand: ☐ R ☐ L **What body part is involved?** Shoulder: ☐ R ☐ L Elbow: ☐ R ☐ L Wrist: ☐ R ☐ L
Hand: ☐ R ☐ L Finger (check side, circle digit): ☐ R ☐ L T 2 3 4 5

When was the onset of symptoms? _____ **Have you had a problem like this before?** ☐ Y ☐ N

On a scale of 0-10 (10 is the worst) how <u>severe</u> is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

Pain is: ☐Constant ☐ Intermittent **Does your pain wake you from your sleep?** ☐ Y ☐ N

Since my problem started, it is: ☐ Getting better ☐ Getting Worse ☐ Unchanged

Do you have: ☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness
☐ Locking/Catching ☐ Giving Way ☐ None

What makes your symptoms <u>worse</u>? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting
☐ Lying in Bed ☐ Bending ☐ Sitting ☐ Coughing ☐ Sneezing

What makes your symptoms <u>better</u>? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐
Other:_____

Have you had any of these treatments? Injection: ☐ Y ☐ N Brace: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N

Were you seen in the E.R. for this problem? ☐ Y ☐ N Which E.R.? _____ Date: _____

Are you here today as a result of an E.R. visit? ☐ Y ☐ N Who saw you in E.R.? _____

What tests/scans have you had for this problem? ☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test
Where?_____

Have you had a <u>prior problem</u> with this same Orthopaedic condition in the past? ☐ Y ☐ N
Explain:_____

Have you already had surgery for a problem in this same area in the past? ☐ Y ☐ N If yes, please describe:

Procedure:_____ Surgeon:_____ City: _____ Date: _____
Procedure:_____ Surgeon:_____ City: _____ Date: _____

Reviewed By: _____ Date:_____

Patient Name: _____

Check the <u>ONE</u> BOX which best describes <u>how your problem started.</u> Then answer the questions below the box you checked.

1. ☐ **NO INJURY** (or onset was: ☐ Gradual or ☐ Sudden). Please indicate below <u>WHY</u> you think it started?

2.☐ **INJURY** (☐ Accident ☐ Sport (NOT Auto or Work) Date:_____ Please specify where and how it happened
What sport?_____ School?_____

3.☐ **INJURY AT WORK** Date:_____ From a: ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐reach

4.☐ **WORK RELATED** (BUT NO INJURY) Date:_____ How did your job cause the problem?

5.☐ **AUTO ACCIDENT** Date:_____ How was your car hit?

Medications, Vitamins or Supplements (and Dosages) ☐ None

_____
_____
_____
_____
_____

Allergies to Any Medications or Metals ☐ None

_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

In the last 3 months, have you had any of these symptoms? If no, mark None.					**NONE**	**YEAR**
1) **GI**	☐ Heartburn	☐ Ulcers	☐ Nausea ☐ Vomiting	☐ Blood in Stool	☐	_____
2) **ENDO**	☐ Fatigue	☐ Heat or Cold Intolerance			☐	_____
3) **CON**	☐ Weight Loss	☐ Fever or Chills			☐	_____
4) **EYE**	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss		☐	_____
5) **ENT**	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing		☐	_____
6) **CV**	☐ Chest Pain	☐ Palpitations			☐	_____
7) **RESP**	☐ Chronic Cough	☐ Shortness of Breath			☐	_____
8) **GU**	☐ Painful Urination	☐ Blood in Urine	☐ Frequent Urination		☐	_____
9) **SK**	☐ Frequent Rashes	☐ Skin Lesions			☐	_____
10)**NEU**	☐ Headaches	☐ Dizziness	☐ Numbness/Tingling		☐	_____
11)**PSY**	☐ Depression	☐ Insomnia	☐ Drug/Alcohol Addiction		☐	_____
12)**HEM**	☐ Easy Bleeding	☐ Easy Bruising	☐ Abnormal Swelling		☐	_____

Reviewed By: _____ Date:_____

Patient Name: _____

PAST MEDICAL & SURGICAL HISTORY

Are you HIV Positive? ☐ Y ☐ N **Have you been exposed to Hepatitis?** ☐ Y ☐ N

Are you Diabetic? ☐ Y ☐ N If yes, treatment: ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

Have you ever had?: ☐ Heart Failure ☐ Heart Attack (year?_____) ☐ High Blood Pressure ☐ Skin Disorder

☐ Kidney Failure ☐ Blood Clots (year? _____) ☐ Stroke ☐ Cancer (location?_____)

☐ Stomach Ulcers ☐ Other Medical Conditions or Joint Disorders _____

☐ **I do not have any of the above conditions**

Are you taking, or have you ever taken, blood thinners? ☐ Y ☐ N If yes, which one? _____

Do you have a known problem with any anti-inflammatories? ☐ Y ☐ N If yes, which one? _____

What operations have you had and when?

_____

_____

Have you been hospitalized (not for surgery) in the last 5 years? ☐ Y ☐ N **If yes:**

_____

Have you or a family member ever had a reaction to anesthesia? ☐ Y ☐ N **If yes:**

_____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, who?

☐ High Blood Pressure _____ ☐ Diabetes _____

☐ Rheumatoid Arthritis _____ ☐ **NONE**

Do any direct relatives have the same condition you are being seen for today? ☐ Y ☐ N

SOCIAL HISTORY

Do you use tobacco? ☐ Y ☐ N If yes, packs per day? _____ If no, were you ever an active smoker? ☐ Y ☐ N

Alcohol use? ☐ Y ☐ N If yes, how often? ☐ Daily ☐ Other _____/week **Marital History:** ☐ M ☐ S ☐ D ☐ W

Occupation:_____ **Employer:** _____

Do you plan to be working 6 months from now? ☐ Y ☐ N

Current Work status? ☐ Regular ☐ Disabled ☐ Retired ☐ Student ☐ Not working due to this problem ☐ Light Duty (How long?_____) When is the last date you worked your regular job?_____

Are you currently receiving or plan to apply for: Disability: ☐ Y ☐ N Worker's Comp: ☐ Y ☐ N Unemployment: ☐ Y ☐ N

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

Signature:_____ **Date:** _____

For Staff Only: HT:_____ WT:_____ BP/P/R: _____

Reviewed By: _____ Date:_____