Anderson Orthopaedic Clinic
Medical History Form—New Patient

****PLEASE THOROUGHLY COMPLETE ALL 3 PAGES.*

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

1) Which hand do you write with? ☐ Right hand ☐ Left hand

2) Which body part is your appointment for today? (Be specific - including if it is Right or Left and/or a particular finger):

_____

3) When or how long ago did symptoms begin? _____

4) Are you experiencing? ☐ Pain ☐ Numbness/tingling ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other:_____

5) On a scale of 0 – 10 (10 is worst pain imaginable) **how severe is your pain most days?** 0 1 2 3 4 5 6 7 8 9 10

6) How would you describe the timing of your symptoms? ☐ Constant ☐ Intermittent ☐ Only with movement

7) Are there any particular motions, activities, or situations that make your symptoms <u>WORSE</u>? If so, what are they?

(Please answer here):_____

8) Is there anything that makes your symptoms <u>BETTER</u>? If so, what? (for example: rest, heat, ice, medication, etc.)

(Please answer here):_____

9) Have you had any treatment for your problem?

- **Cortisone injection** ☐ Y ☐ N **If "yes" did it help?** ☐ Y ☐ N **& How long did it help for?** _____
- **Physical Therapy** ☐ Y ☐ N **If "yes" did it help?** ☐ Y ☐ N ☐ Made it worse
- **Brace** ☐ Y ☐ N **If "yes" did it help?** ☐ Y ☐ N
- **Medication** ☐ Y ☐ N **If "yes" did it help?** ☐ Y ☐ N **Name of medication:** _____
  (Including any over-the-counter medications)

10) In what context did you first notice symptoms?

☐ Gradually occurred ☐ Awoke one day with pain ☐ Repetitive use ☐ Work injury ☐ Sports injury
☐ Other injury ☐ Not sure

- **If it was an injury:**
  - **Date of Injury:** _____
  - **How did it happen?** _____
  - **If a sport, which sport?** _____

11) Do your symptoms wake you from your sleep? ☐ Y ☐ N

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

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

11) Have you had any tests for this problem? ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Nerve Test (EMG)

- **Where?** _____

Reviewed By: _____ Date:_____

Patient Name: _____

12) Have you had similar problem in this same area in the past? ☐ Y ☐ N

- **Explain:** _____

13) 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: _____

14) W**ere you seen in the E.R. for this problem?** ☐ Y ☐ N Which E.R.? _____

- Date: _____

MEDICATIONS: (and Dosages) ☐ None

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: (Medications or Metals)

☐ No Allergies

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

In the last month, have you had any of these symptoms? (Check only those for which your answer is "yes.")

1) **GI** ☐ Heartburn ☐ Ulcers ☐ Nausea ☐ Vomiting ☐ Blood in Stool
2) **ENDO** ☐ Fatigue ☐ Heat or Cold Intolerance
3) **CON** ☐ Unintentional Weight Loss ☐ Fever ☐ Chills
4) **EYE** ☐ Blurred Vision ☐ Double Vision ☐ Vision Loss
5) **ENT** ☐ Hearing Loss ☐ Hoarseness ☐ Trouble Swallowing
6) **CV** ☐ Chest Pain ☐ Palpitations
7) **RESP** ☐ 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 ☐ Limb Swelling

☐ **CHECK HERE IF "NO" TO ALL**

Reviewed By: _____ Date:_____

Patient Name: _____

PAST MEDICAL & SURGICAL HISTORY

1) **Are you Diabetic?** ☐ Y ☐ N **If "yes", treatment:** ☐ Insulin ☐ Oral Medications ☐ Diet ☐ None

2) **Are you HIV Positive?** ☐ Y ☐ N

3) **Do you have Hepatitis?** ☐ Y ☐ N

4) **Do you have or have you ever had?:** ☐ Heart Failure ☐ Heart Attack (year? _____) ☐ High Blood Pressure

☐ Kidney Disease ☐ Blood Clot (year? _____) ☐ Stroke (year? _____) ☐ Cancer (location?_____)

☐ Stomach Ulcers ☐ Skin Disorder (like psoriasis) ☐ Autoimmune disease (like rheumatoid arthritis)

☐ Any OTHER Medical Conditions or Joint Disorders _____

☐ **I DO NOT have any medical conditions**

5) **Are you taking blood thinners?** ☐ Y ☐ N If yes, which one?_____

6) **Is there a medical reason you are NOT allowed to take anti-inflammatories (like Advil or Aleve)?** ☐ Y ☐ N

- If yes, what is the reason? _____

7) **What operations have you had and when?**

_____

_____

8) **Have you or a family member ever had a <u>serious</u> reaction to anesthesia?** ☐ Y ☐ N **If yes:**

_____

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

☐ High Blood Pressure _____ ☐ Diabetes _____

☐ Arthritis → If yes, is it: ☐ Osteoarthritis (age, wear & tear) OR ☐ Rheumatoid arthritis (autoimmune disease)

☐ **NO Significant Family History** ☐ **OTHER Significant Family History** _____

<u>SOCIAL HISTORY</u>

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:** _____

Current Work status? ☐ Regular ☐ Disabled ☐ Retired ☐ Student ☐ Not working due to this problem ☐ Light Duty

If you are under Workman's Compensation, when was the last time you worked? _____

Patient Signature:_____ **Date:** _____

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

Reviewed By: _____ Date:_____