Anderson Orthopaedic Clinic
Medical History Form—New Patient

Patient Name: _____ **Appointment Date:**_____ **with Dr.**_____**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:_____

What body part is involved? (Please mark the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐	☐

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

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 ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bowel/bladder control
☐ Locking/Catching ☐ Giving Way ☐ Bruises ☐ None

What makes your symptoms <u>worse</u>? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in Bed ☐ Bending ☐ Squatting
☐ Kneeling ☐ Stairs ☐ 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 Cane/Crutch: ☐ 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.? _____ ☐ MD ☐ PA

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 either recently or in the past? ☐ Y ☐ N If yes, list all procedures below:

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

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

Do your other joints have: ☐ Morning stiffness over 30 minutes ☐ Joint Pain or Swelling ☐ Back Pain ☐ Gout ☐ Rheumatoid Arthritis
☐ Osteoporosis ☐ Prior Fracture (which bone_____) ☐ None of these

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

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?

Comments:

FOR STAFF ONLY:

HT:_____ WT:_____ BP/P/R: _____ Reviewed By: _____ Date:_____

Patient Name: _____

REVIEW OF SYSTEMS

Have you had any of these symptoms? If no, mark None.

					NONE	YEAR
1) **GI**	☐ Heartburn	☐ Nausea	☐ Vomiting		☐	_____
	☐ Ulcers	☐ Blood in Stool				
2) **ENDO**	☐ Fatigue	☐ Heat or Cold Intolerance			☐	_____
3) **CON**	☐ Weight Loss	☐ Loss of Appetite			☐	_____
4) **EYE**	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss		☐	_____
5) **ENT**	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing		☐	_____
6) **CV**	☐ Chest Pain	☐ Palpitations			☐	_____
7) **RS**	☐ Chronic Cough	☐ Shortness of Breath			☐	_____
8) **GU**	☐ Painful Urination	☐ Blood in Urine	☐ Frequent Urination		☐	_____
9) **SK**	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps	☐ Psoriasis	☐	_____
10) **NEU**	☐ Headaches	☐ Dizziness	☐ Seizures		☐	_____
11) **PSY**	☐ Depression	☐ Sleep Disorder	☐ Drug/Alcohol Addiction		☐	_____
12) **HEM**	☐ Easy Bleeding	☐ Easy Bruising	☐ Abnormal Swelling		☐	_____

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

CURRENT MEDICATIONS

What Medications are you taking now?

_____

_____

_____

_____

_____

_____

_____

Allergic to any Medication?

☐ Y ☐ N If yes, please list and describe reactions:

_____

_____

_____

PAST MEDICAL HISTORY

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

☐ Ankle Swelling ☐ Kidney Failure ☐ Blood Clots (year? _____) ☐ Stroke

☐ Cancer (location?_____) ☐ Stomach Ulcers

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

Do you have a known problem with any anti-inflammatories?_____

Are you taking, or have you ever taken, blood thinners? ☐ Y ☐ N

If yes, which one(s)? _____

Are you allergic to any metals? ☐ Y ☐ N

If yes, which one(s)? _____

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

☐ High Blood Pressure _____ ☐ Diabetes _____

☐ Rheumatoid Arthritis _____ ☐ **NONE**

PAST SURGICAL HISTORY

What operations have you had & when?

_____

_____

_____

Have you or a family member ever had a reaction to anesthesia? ☐ Y ☐ N

If yes:_____

_____

Past Hospitalizations (Not for Surgery)

_____

_____

_____

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

How many people live with you? _____ **Occupation:**_____ **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.

Patient Signature: _____ Date: _____

FOR STAFF ONLY:

Reviewed By: _____ Date:_____