orthopedic ONE

Medical History Form

PATIENT NAME

Last: _____ First: _____ Appt. Date _____

Date of Birth: _____ Height: ___ ft. ____ in. Weight: _____ lbs. ❑ Left-Handed ❑ Right-Handed Occupation _____

HISTORY OF PRESENT PROBLEM

Briefly describe the body parts you are being seen for today: _____

_____ ❑ Left ❑ Right

Was this the result of an accident? ❑ Y ❑ N Date of accident: _____ Where did the injury occur? ❑ Work ❑ Auto ❑ Home ❑ Other

Please describe the accident: _____

Have you been previously seen for this condition? ❑ Y ❑ N If so, names of physicians: _____

Is this condition being covered by Worker's Compensation? ❑ Y ❑ N Is there a lawsuit or litigation pending in regard to your injury? ❑ Y ❑ N

Last Date Worked: _____ Current Work Restrictions: _____ By Whom? _____

PAIN SCALE (Circle one)	**NO PAIN**				**MODERATE**					**SEVERE PAIN**	
AT REST	0	1	2	3	4	5	6	7	8	9	10
DURING ACTIVITY	0	1	2	3	4	5	6	7	8	9	10

Does pain wake you during sleep? ❑ Y ❑ N

If so, describe: _____

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing: ❑ X-RAY ❑ CT ❑ MRI ❑ EMG ❑ OTHER (SPECIFY): _____

Medications & Injections tried for this problem: _____

Physical Therapy / Location / # of visits: _____

Other treatment for this injury: _____

MEDICATIONS (List all current medications - prescription and non-prescription, vitamins and supplements) ❑ List on Record

Medication	Dose/How taken/How Often	Medication	Dose/How taken/How Often
1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

ALLERGIES and REACTIONS (List all allergies to medications, food, metals, any skin allergies to iodine or adhesive tape)

Do you have any metal allergies such as nickel? ❑ Y ❑ N If yes, please name them: _____

Do you have a latex allergy? ❑ Y ❑ N Do you have a poultry allergy? ❑ Y ❑ N

Name of Allergy Item	Reacton	Name of Allergy Item	Reaction
1		3	
2		4	

SOCIAL HISTORY

Tobacco Use: ❑ Y ❑ N If yes, please list pack per day for how many years: _____

Alcohol Use: ❑ Y ❑ N If yes, what type of alcohol and how many drinks per day: _____

Caffeine Use: ❑ Y ❑ N If yes, please indicate type and frequency: _____

Current or previously treated for Alcohol / Drug Use Disorder: ❑ Y ❑ N

Current or previously treated by a Chronic Pain Management Specialist? ❑ Y ❑ N If yes, name of Specialist: _____

Do you regularly participate in sports or physical activity? ❑ Y ❑ N If so, what activity and how frequently: _____

Have you had a fall in the past 12 months? ❑ Y ❑ N If so, how many falls have you had in the past 12 months? _____

LIVING ARRANGEMENTS (Please check all that apply)

❑ Alone ❑ Caregiver for others ❑ Family/Roommate ❑ Dependent on a caregiver for daily activities ❑ Retirement Community

❑ Skilled Nursing Facility ❑ Assisted Living ❑ Name of Nursing/Retirement Facility _____

LIST PRIOR SURGERIES		**LIST BROKEN BONES**	
	Date		Date
	Date		Date
	Date		Date
	Date		Date

PAST MEDICAL HISTORY

Do you have sleep apnea? ❑ Y ❑ N If yes, do you use C-PAP or Bi-PAP?: ❑ Y ❑ N

Device Settings _____ When used: ❑ Night time ❑ As needed ❑ Continuously

Have you seen a Cardiologist? ❑ Y ❑ N If yes, name of Cardiologist _____

Do you have a pacemaker? ❑ Y ❑ N If yes, Please specify _____

Do you have a defibrillator? ❑ Y ❑ N If yes, what Make or Manufacturer _____

Have you had a flu vaccine? ❑ Y ❑ N If yes, what date _____ Have you had a pneumonia vaccine? ❑ Y ❑ N If yes, what date _____

PATIENT NAME

Last: _____ First: _____

Date of Birth: _____

PAST MEDICAL HISTORY (continued

BEHAVIORAL HEALTH
- ❑Y ❑N Alcohol dependency
- ❑Y ❑N Anxiety
- ❑Y ❑N Behavioral Health Diagnosis
- ❑Y ❑N Bipolar Disorder
- ❑Y ❑N Dementia / Alzheimer's disease (circle)
- ❑Y ❑N Depression
- ❑Y ❑N Opioid dependence
- ❑Y ❑N Post-Traumatic stress disorder
- ❑Y ❑N Schizophrenia

CARDIAC (Heart / Circulation)
- ❑Y ❑N Atrial Fib (Irregular heart rhythm)
- ❑Y ❑N Circulation Problems
- ❑Y ❑N Congestive Heart Failure
- ❑Y ❑N Blood Clots in Legs / Lungs (circle)
- ❑Y ❑N Heart Attack
- ❑Y ❑N Heart Surgery Stents / CABG (circle)
- ❑Y ❑N High Blood Pressure
- ❑Y ❑N High Cholesterol
- ❑Y ❑N Mitral valve prolapse
- ❑Y ❑N Peripheral Vascular Disease
- ❑Y ❑N Stroke/TIA

EAR NOSE THROAT
- ❑Y ❑N Anesthesia Complications

ENDOCRINE
- ❑Y ❑N Diabetes ❑ Type 1 ❑ Type 2
  Most Recent Hg A1C _____
- ❑Y ❑N Lupus
- ❑Y ❑N Thyroid Disorder

GASTROINTESTINAL
- ❑Y ❑N GI Bleed
- ❑Y ❑N Heartburn / Chronic Constipation / Diverticulitis (circle)
- ❑Y ❑N Stomach Ulcers

GENERAL
- ❑Y ❑N Cancer
- ❑Y ❑N Claustrophobia
- ❑Y ❑N Hepatitis
- ❑Y ❑N HIV/AIDS
- ❑Y ❑N Kidney Disease
  ❑ Dialysis ❑ Treatment
  ❑ Transplant
- ❑Y ❑N Liver Disease
- ❑Y ❑N Malignant Hyperthermia
- ❑Y ❑N Pregnancy (current or recent)
  Date: _____
- ❑Y ❑N Sexually Transmitted Disease

HEMATOLOGY
- ❑Y ❑N Bleeding Disorder
- ❑Y ❑N Sickle Cell Disorder

MUSCULOSKELETAL
- ❑Y ❑N Gout
- ❑Y ❑N Osteoarthritis
- ❑Y ❑N Osteoporosis
- ❑Y ❑N Rheumatoid Arthritis
- ❑Y ❑N Scoliosis
- ❑Y ❑N TMJ

NEUROLOGIC
- ❑Y ❑N Epilepsy / Seizure Disorder
- ❑Y ❑N Fibromyalgia
- ❑Y ❑N Multiple Sclerosis
- ❑Y ❑N Neuropathy
- ❑Y ❑N Parkinson's Disease
- ❑Y ❑N Restless Legs

RESPIRATORY
- ❑Y ❑N Asthma
- ❑Y ❑N Bronchitis / Emphysema / COPD (circle)
- ❑Y ❑N Pneumonia
- ❑Y ❑N Tuberculosis

SKIN
- ❑Y ❑N MRSA / Skin Staph Infection
- ❑Y ❑N Psoriasis

URINARY
- ❑Y ❑N Bladder Disease
- ❑Y ❑N Difficult Catheter Placement
- ❑Y ❑N Prostate Enlarged

VISION
- ❑Y ❑N Glaucoma

FAMILY HISTORY (Please check any that have occurred in any blood relative)

	Family Relationship		Family Relationship		Family Relationship
❑ Aneurysm	_____	❑ Depression	_____	❑ Nerve disease	_____
❑ Blood Clots	_____	❑ Heart Disease	_____	❑ Osteoarthritis	_____
❑ Bleeding Disorder	_____	❑ High Blood Pressure	_____	❑ Osteoporosis	_____
❑ Cancer	_____	❑ Malignant Hyperthermia	_____	❑ Rheumatological	_____
❑ Diabetes	_____	❑ Muscle or Bone Disease	_____	❑ Thyroid disease	_____

CURRENT SYMPTOMS (Review of Systems)

BEHAVIORAL HEALTH
- ❑Y ❑N Anxiety
- ❑Y ❑N Depression
- ❑Y ❑N Panic Attacks

CARDIAC (Heart / Circulation)
- ❑Y ❑N Chest Pain or pressure
- ❑Y ❑N Irregular Heartbeat
- ❑Y ❑N Leg Pain with walking
- ❑Y ❑N Palpitations
- ❑Y ❑N Swelling of ankles or feet
- ❑Y ❑N Varicose Veins

EAR NOSE THROAT
- ❑Y ❑N Mouth or Dental Infection
- ❑Y ❑N Trouble Hearing
- ❑Y ❑N Trouble Speaking
- ❑Y ❑N Trouble Swallowing

ENDOCRINE
- ❑Y ❑N Cold Intolerance
- ❑Y ❑N Heat Intolerance
- ❑Y ❑N Increased Appetite

GASTROINTESTINAL
- ❑Y ❑N Abdominal pain
- ❑Y ❑N Chronic Diarrhea
- ❑Y ❑N Constipation
- ❑Y ❑N Heartburn
- ❑Y ❑N Nausea & Vomiting

GENERAL
- ❑Y ❑N Chills
- ❑Y ❑N Fever
- ❑Y ❑N Fatigue
- ❑Y ❑N Inability to sleep
- ❑Y ❑N Night Sweats
- ❑Y ❑N Travel outside country in past month?
- ❑Y ❑N Weight Gain Over the past year Lbs. _____
- ❑Y ❑N Weight Loss Over the past year Lbs. _____

HEMATOLOGY
- ❑Y ❑N Anemia
- ❑Y ❑N Easy Bruising
- ❑Y ❑N Prolonged Bleeding

MUSCULOSKELETAL
- ❑Y ❑N Neck Pain
- ❑Y ❑N Back Pain
- ❑Y ❑N Deformity
- ❑Y ❑N General muscle weakness
- ❑Y ❑N Muscle aches
- ❑Y ❑N Multiple joint pain – Stiffness or Swelling (circle)
- ❑Y ❑N TMJ

NEUROLOGIC
- ❑Y ❑N Burning Sensation
- ❑Y ❑N Cramps
- ❑Y ❑N Loss of Sensation
- ❑Y ❑N Migraines
- ❑Y ❑N Paralysis
- ❑Y ❑N Tingling/numbness
- ❑Y ❑N Weakness

RESPIRATORY
- ❑Y ❑N Cough
- ❑Y ❑N Difficulty breathing
- ❑Y ❑N Shortness of breath at rest

SKIN
- ❑Y ❑N Drainage
- ❑Y ❑N Rash
- ❑Y ❑N Sores or Ulcers (circle)
- ❑Y ❑N Unusual bruises

URINARY
- ❑Y ❑N Difficulty urinating
- ❑Y ❑N Urinary incontinence

VISION
- ❑Y ❑N Blurred vision
- ❑Y ❑N Double vision

If you checked current symptoms, are you receiving treatment? ❑Y ❑N

If yes, please describe _____

Patient Signature _____ Date _____

By signing this form I attest that the above information is true and correct to the best of my belief.

HISTORY REVIEWED BY - (Office Use Only)

Name/Signature _____ Date _____