orthopedic ONE

Medical History Form

PATIENT NAME

Appointment Date _____

Last: _____ First: _____

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
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____
7	_____	_____
8	_____	_____

PATIENT NAME

Last: _____ First: _____

Date of Birth: _____

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	Reaction
1	_____	_____
2	_____	_____
3	_____	_____
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

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

LIST BROKEN BONES

_____ 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 _____

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PAST MEDICAL HISTORY (continued)

BEHAVIORAL HEALTH

❑Y ❑N Alcohol dependency
❑Y ❑N Anxiety
❑Y ❑N Behavioral Health Diagnosis
❑Y ❑N Bipolar Disorder
❑Y ❑N Demenita / 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

PATIENT NAME

Last: _____ First: _____

Date of Birth: _____

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

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

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 _____