MEDICAL HISTORY

Your current and past health information are very important to your care and treatment at Orthopedic One.

PATIENT NAME:	ACCOUNT NO:	Date:

SS#:	Referring Physician Information:	Family Physician Information:
DATE OF BIRTH:	Name:	Name:
Weight / HEIGHT / Age	Address:	Address:
❑Left handed ❑Right handed	Phone:	Phone:

HISTORY OF PRESENT PROBLEM

Reason for today's visit: ______________________

Was this the result of an accident? ❑N ❑Y If yes Date of accident and please describe. Date: __________

Where did the injury occur? ❑Work ❑Auto ❑Home Other ______________

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

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

PRESCRIPTION HISTORY CONSENT

By initialing below, I authorize Orthopedic One to request and use any and all available prescription history from external sources for treatment purposes, including other healthcare providers and pharmacy benefit payers.

Initials -------------------------

PHARMACY INFORMATION:

Please provide your preferred pharmacy information. This will help us in the event we need to call in a prescription for you or send a prescription over a secure electronic connection to your pharmacy.

Name of Pharmacy:

Street Address of Pharmacy (including city and zip code):

Pharmacy phone number: (   )   -

ALLERGIES and REACTIONS (List allergies to Medications, Metals or Latex)

Name of Allergy Item	Reaction	Name Allergy Item	Reaction
1		4	
2		5	
3		6	

Do you have any metal allergies? ❑N ❑Y If Yes, please list above

Do you have a latex allergy? ❑N ❑Y

EVALUATION OF PAIN / DISCOMFORT

What body part is affected? ❑LEFT ❑RIGHT

When did the problem start?

When does the problem occur? | How long does it last?

What makes it feel better?

What makes it feel worse?

PAIN SCALE		MILD			MODERATE			SEVERE			
(Circle one number)	NO PAIN	1	2	3	4	5	6	7	8	9	10 SEVERE PAIN

List activities you are unable to do because of pain.

Does pain wake you during sleep? ❑ No ❑Yes - Please describe

Patient Name ________________________________ **Date of Birth**______________________

PREVIOUS TREATMENT FOR THIS PROBLEM			
Diagnostic Testing: ❑X-RAY ❑CT ❑MRI ❑EMG OTHER:			
Medications:			
Physical Therapy/ Location:			
Other treatment for this injury:			Names of Physicians
Have other Physicians seen you for this problem?	❑No	❑Yes	
Is this condition being covered by Worker's Compensation?	❑No	❑Yes	
Is there a lawsuit or litigation pending in regard to your injury?	❑No	❑Yes	
Last Date Worked:			
Current Work Restrictions		By Whom?	

LIST PRIOR SURGERIES		LIST BROKEN BONES	
Description:	Date:	Description:	Date:
Description:	Date:	Description:	Date:
Description:	Date:	Description:	Date:
Description:	Date:	Description:	Date:

PAST MEDICAL HISTORY

❑N ❑Y **Blood Clots in legs or lungs**	❑N ❑Y Parkinson's Disease	❑N ❑Y Enlarged Prostate
❑N ❑Y High Blood Pressure	❑N ❑Y Multiple Sclerosis	❑N ❑Y Bladder Disease
❑N ❑Y Congestive Heart Failure	❑N ❑Y Hepatitis	❑N ❑Y Kidney Disease
❑N ❑Y Heart Disease	❑N ❑Y Stomach Ulcers	❑N ❑Y Seizure Disorder
❑N ❑Y Mitral valve prolapsed	❑N ❑Y Irritable bowel	❑N ❑Y Thyroid Disorder
❑N ❑Y Heart Attack	❑N ❑Y Heartburn (GERD)	❑N ❑Y Cancer
❑N ❑Y Irregular Heart Beat	❑N ❑Y Liver Disease	❑N ❑Y Glaucoma
❑N ❑Y High Cholesterol	❑N ❑Y Pneumonia	❑N ❑Y Osteoarthritis
❑N ❑Y Stroke	❑N ❑Y Asthma	❑N ❑Y TMJ
❑N ❑Y Circulation problems	❑N ❑Y Tuberculosis	❑N ❑Y Osteoporosis
❑N ❑Y Bleeding Disorder	❑N ❑Y Emphysema	❑N ❑Y Rheumatoid Arthritis
❑N ❑Y Diabetes	❑N ❑Y Bronchitis	❑N ❑Y Restless legs
❑N ❑Y Lupus	❑N ❑Y Skin Disorder	❑N ❑Y Gout
❑N ❑Y Pregnancy (current or recent) Date: ______________		❑N ❑Y AIDS/HIV
		❑ Other: ____________________

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

When used: ❑nighttime ❑as needed ❑continuously

Do you have cardiac stents? ❑N ❑Y If yes, please list date(s): ____________________

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

Do you have a defibrillator? ❑N ❑Y If yes, Please specify: ____________________

FAMILY HISTORY please check any that have occurred in any blood relatives

	Family Relationship		Family Relationship
❑ **Blood Clots in legs or lungs**	______	❑ Heart Disease	______
❑ Bleeding Disorder	______	❑ Aneurysm	______
❑ Osteoporosis	______	❑ High blood pressure	______
❑ Osteoarthritis	______	❑ Diabetes	______
❑ Rheumatoid arthritis	______	❑ Nerve disease	______
❑ Muscle or Bone Disease	______	❑ Depression	______
❑ Cancer	______	❑ Lupus	______
❑ Thyroid disease	______	❑ Malignant Hyperthermia	______
		❑ Fibromyalgia	______

❑ Other ____

Patient Name ________________________________ **Date of Birth**______________________

SOCIAL HISTORY

❑Married ❑Domestic Partner ❑Single ❑Divorced ❑Widow/ Widower ❑Separated

RESIDENCE

❑Alone ❑With Family ❑With Friends ❑Nursing Home ❑Retirement Home
Name of assisted living facility: ❑Other:

USER OF:

Tobacco: ❑No ❑Yes Are you a: ❑Current Smoker ❑Nonsmoker ❑Former Smoker ❑Smoker, current status unknown ❑Unknown if ever smoked

Question		
If a "current smoker', how often do you smoke cigarettes?	❑ Every day	❑ Some days, but not every day
If a "current smoker', how many cigarettes a day do you smoke?	❑ 5 or less ❑ 21-30	❑ 6-10 ❑ 11-20 ❑ 31 or more
If a "current smoker', how soon after you wake up do you smoke your first cigarette?	❑ within 5 minutes ❑ 31-60 minutes	❑ 6-30 minutes ❑ after 60 minutes
If a "current smoker', are you interested in quitting?	❑ Ready to quit ❑ Not ready to quit	❑ Thinking about quitting

Caffeine (colas, tea, coffee) ❑N ❑Y If yes please indicate type and frequency: ______________________________

Alcohol ❑N ❑Y If yes please indicate frequency: ______________________________

Illicit Drug Use ❑N ❑Y If yes please indicate type: ______________________________

CURRENT SYMPTOMS (Review of Systems)

General
- ❑N ❑Y Fever
- ❑N ❑Y Chills
- ❑N ❑Y Weight loss
- ❑N ❑Y Weight gain
- ❑N ❑Y Heavy Sweating
- ❑N ❑Y Night Sweats
- ❑N ❑Y Fatigue
- ❑N ❑Y Inability to sleep
- ❑N ❑Y Travelled in the past month?

Skin
- ❑N ❑Y Rash
- ❑N ❑Y Sores
- ❑N ❑Y Ulcers
- ❑N ❑Y Discoloration
- ❑N ❑Y Itching
- ❑N ❑Y Dry skin
- ❑N ❑Y Drainage
- ❑N ❑Y Birthmarks

Ear Nose Throat
- ❑N ❑Y Trouble speaking
- ❑N ❑Y Trouble hearing
- ❑N ❑Y Trouble swallowing
- ❑N ❑Y Mouth or dental infection

Vision
- ❑N ❑Y Double vision
- ❑N ❑Y Blurred vision
- ❑N ❑Y Frequent or unusual headaches

Respiratory
- ❑N ❑Y Shortness of breath at rest
- ❑N ❑Y Difficulty breathing
- ❑N ❑Y Cough
- ❑N ❑Y Productive cough

Cardiac
- ❑N ❑Y Palpitations
- ❑N ❑Y Chest pain at rest
- ❑N ❑Y Chest pain or pressure
- ❑N ❑Y Foot swelling
- ❑N ❑Y Leg pain with walking
- ❑N ❑Y Swelling of ankles
- ❑N ❑Y Blood clots in legs or lungs
- ❑N ❑Y Varicose veins
- ❑N ❑Y Irregular heartbeat

Gastrointestinal
- ❑N ❑Y Abdominal pain
- ❑N ❑Y Heartburn
- ❑N ❑Y Constipation
- ❑N ❑Y Chronic diarrhea
- ❑N ❑Y Nausea
- ❑N ❑Y Vomiting

Urinary
- ❑N ❑Y Urinary incontinence
- ❑N ❑Y Difficulty urinating
- ❑N ❑Y Frequent urination
- ❑N ❑Y Urgency of urination
- ❑N ❑Y Retention of Urine
- ❑N ❑Y Painful Urination

Endocrine
- ❑N ❑Y Heat intolerance
- ❑N ❑Y Cold intolerance
- ❑N ❑Y Increased appetite

Neurologic
- ❑N ❑Y Tingling/numbness
- ❑N ❑Y Burning sensation
- ❑N ❑Y Weakness
- ❑N ❑Y Cramps
- ❑N ❑Y Paralysis
- ❑N ❑Y Loss of sensation

Musculoskeletal
- ❑N ❑Y Neck pain
- ❑N ❑Y Back pain
- ❑N ❑Y Deformity
- ❑N ❑Y Muscle aches
- ❑N ❑Y Multiple joint swelling
- ❑N ❑Y Multiple joint pain
- ❑N ❑Y Multiple joint stiffness
- ❑N ❑Y Swollen joints
- ❑N ❑Y General muscle weakness

Hematology
- ❑N ❑Y Easy bruising
- ❑N ❑Y Anemia
- ❑N ❑Y Prolonged bleeding
- ❑N ❑Y Bleeding problems

Psychiatric
- ❑N ❑Y Depressed mood
- ❑N ❑Y Anxiety
- ❑N ❑Y Panic attacks
- ❑N ❑Y Episodes of mania

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: Date

Name: Date

Supplemental Spine Patient History

orthopedic ONE

Patient Name: ____ Date of Birth____________ Date: ______________________

Primary Care Physician: ____________________________ (City) ____

Referred By: ______________________________________ Patient Occupation: _____________________________________

REASON FOR VISIT: ____

When did it start? ___________________________________ What makes it worse? _________________________________

Did it come on suddenly or gradually? ____________________ What makes it better? _________________________________

Where is it located? __________________________________ Describe the sensation. _______________________________

Do you have pain at night? ________________ Describe any effect on work activity:_____________________________________

Have you had a weight loss or gain in the past 6 months? If yes, please describe. ____

Have you had a loss of bowel or bladder control? If yes, please describe. ____

Does the problem effect you psychologically or emotionally?____

Have you had any prior problems with alcohol or drug abuse? ____

List any prior testing performed for this problem____

Have you ever been abused? ❑Y ❑N

List each medication and treatment that you have tried for this problem.

Include over-the-counter, prescription, therapy, alternative medicines.

____

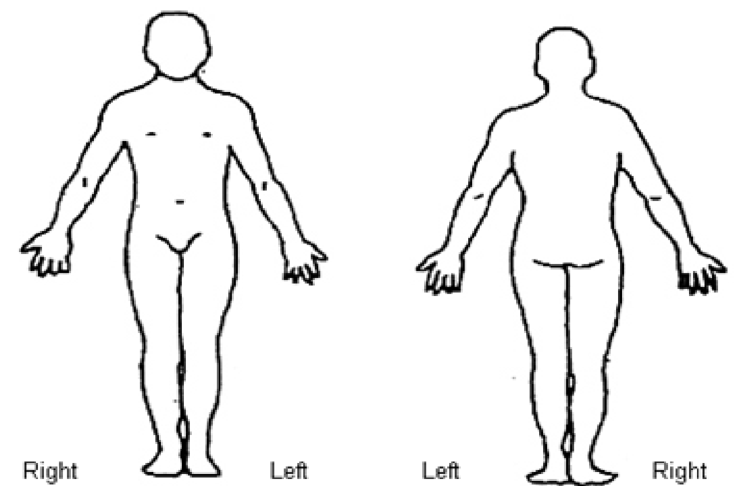
____

____

____

Using the symbols below, mark on the drawings which areas of your body you feel the described sensations:

Numbness	=====
Dull Ache	ooooo
Burning	xxxxx
Sharp Stabbing	////////
Pins and Needles	++++



Using the following scale, mark the box corresponding to the severity of your pain today: (0=no pain, 10=excruciating pain)

0	1	2	3	4	5	6	7	8	9	10