MEDICAL HISTORY

orthopedic ONE

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.

Patient 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	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	SEVERE PAIN

List activities are you 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

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

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:

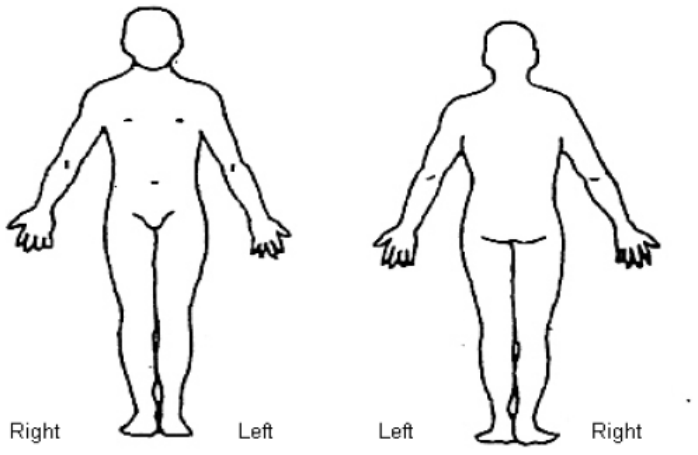
Numbness =====

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