orthopedic ONE

Medical History Form

PATIENT NAME

Last: _____ First: _____ Appt. Date _____

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

Name of Primary Care Provider: _____

Name of Referring Provider: _____

HISTORY OF PRESENT PROBLEM

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

_____

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

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)

Metal allergies such as nickel? ❑ Y ❑ N If yes, please name them: _____

Latex allergy? ❑ Y ❑ N

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

PAST MEDICAL HISTORY

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

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

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

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

LIST PRIOR SURGERIES

	Date		Date
	Date		Date
	Date		Date

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

	Family Relationship		**Family Relationship**
❑ Bleeding Disorder	_____	❑ Malignant Hyperthermia	_____
❑ Blood Clots	_____	❑ Rheumatological	_____

PATIENT NAME

Last: _____ First: _____ Date of Birth: _____

PAST MEDICAL HISTORY

MUSCULOSKELETAL
❑ Y ❑ N Gout
❑ Y ❑ N Lupus
❑ Y ❑ N Osteoarthritis
❑ Y ❑ N Osteoporosis
❑ Y ❑ N Rheumatoid Arthritis
❑ Y ❑ N Scoliosis
❑ Y ❑ N Other _____

NEUROLOGIC
❑ Y ❑ N Epilepsy / Seizure Disorder
❑ Y ❑ N Fibromyalgia
❑ Y ❑ N Multiple Sclerosis
❑ Y ❑ N Neuropathy
❑ Y ❑ N Parkinson's Disease
❑ Y ❑ N Stroke / TIA
❑ Y ❑ N Other _____

GENERAL
❑ Y ❑ N Anesthesia Complications
❑ Y ❑ N Cancer Type _____
❑ Y ❑ N Hepatitis
❑ Y ❑ N HIV/AIDS
❑ Y ❑ N Hypothyroid
❑ Y ❑ N Kidney Disease
❑ Dialysis ❑ Treatment
❑ Transplant
❑ Y ❑ N Liver Disease
❑ Y ❑ N Malignant Hyperthermia
❑ Y ❑ N Pregnancy

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

CARDIAC (Heart / Circulation)
❑ Y ❑ N Atrial Fib (Irregular heart rhythm)
❑ 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 Peripheral Vascular Disease

DIABETES
❑ Y ❑ N Diabetes
❑ Type 1 ❑ Type 2
Most Recent Hg 1C_____

GASTROINTESTINAL
❑ Y ❑ N Chronic Constipation
❑ Y ❑ N GI Bleed
❑ Y ❑ N Heartburn / Stomach Ulcers

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

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

SKIN
❑ Y ❑ N MRSA / Skin Staph Infection (circle)
❑ Y ❑ N Psoriasis

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

CURRENT SYMPTOMS (Review of Systems)

MUSCULOSKELETAL
❑ Y ❑ N Joint laxity /Dislocations
❑ Y ❑ N Neck / Back pain
❑ Y ❑ N Multiple joint pain – Stiffness or Swelling (circle)

NEUROLOGIC
❑ Y ❑ N Burning Sensation
❑ Y ❑ N Tingling/numbness
❑ Y ❑ N Weakness

GENERAL
❑ Y ❑ N Chills / Fever
❑ Y ❑ N Inability to sleep
❑ Y ❑ N Night Sweats
❑ Y ❑ N Weight Loss over the past year Lbs. _____

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 Swelling of ankles or feet

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

ENDOCRINE
❑ Y ❑ N Cold / Heat Intolerance

GASTROINTESTINAL
❑ Y ❑ N Chronic Diarrhea
❑ Y ❑ N Constipation
❑ Y ❑ N Heartburn

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

RESPIRATORY
❑ Y ❑ N Difficulty breathing
❑ Y ❑ N Persistant cough
❑ Y ❑ N Shortness of breath at rest

SKIN
❑ Y ❑ N Rash
❑ Y ❑ N Sores

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

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

❑ **OTHER** _____

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

If yes, please describe _____

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: _____

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: _____

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_____

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 _____

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:

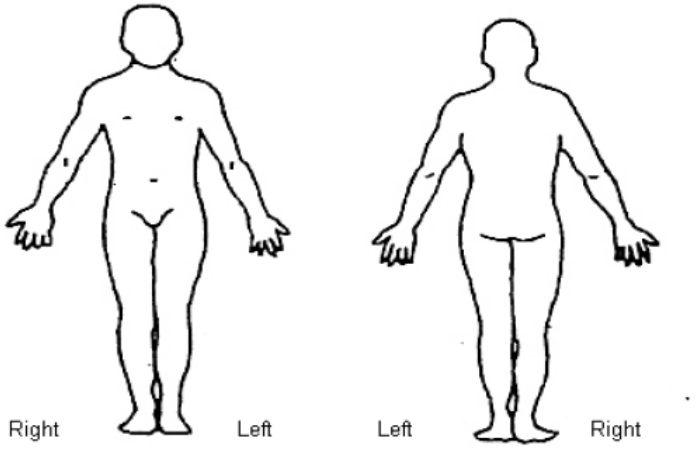
Numbness =====

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