



New Orthopedic Patient History

Name: _____ Date of Birth ___/___/___ Date: ___/___/___

Age _____ Gender: Female Male Referring Physician: _____

Part of body being seen for today: Right Left Both _____

Check the box which best describes how your problem started. Answer the questions related to the box you checked.

No Injury Onset was: Gradual Sudden
Onset Date: _____

Injury Accident Sport
Date of injury: _____

Injury at Work Date of injury: _____
Lift Twist Fall Bend Pull Reach Repetitive

Auto Accident
Date of Accident: _____

Description of Injury/Accident

Have you had a problem like this before? Yes No

Has this problem been previously evaluated? Yes No

Were you seen in the Emergency Room for this Problem? Yes No Which E.R. _____

Were you seen in an Urgent Care Clinic? Yes No Which Clinic: _____

What tests or scans have you had for this problem?

X-rays MRI CAT scan Bone Scan Nerve Test (EMG/NVC) Other: _____

On a scale of 0-10 (10 is the worst), how severe is your pain? (circle) 1 2 3 4 5 6 7 8 9 10

What is the quality of your pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is Constant Intermittent (comes & goes). Does the pain wake you from sleep? Yes No

Does the pain radiate anywhere? Yes No Where? _____

I experience: Swelling Bruising Numbness Tingling Weakness Loss of control of bowel or bladder

Locking/Catching Giving way Pain Stiffness Other _____

Since my problem started, it is: Getting Better Getting Worse Unchanged

What makes your symptoms worse: Standing Walking Lifting Twisting Bending Stairs Exercise

Squatting Kneeling Sitting Coughing Sneezing Lying in bed Other _____

What makes your symptoms better? Rest Elevation Ice Heat Other _____

Review of Symptoms: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check “no problem” if none of the symptoms apply to you.

General

- Unexplained weight loss/gains
- Unexplained fatigue
- Weakness
- Fever, chills
- No Problems**

Skin

- New or change in mole
- Rash/itching
- No Problems**

Eyes/Ears/Nose/Throat

- Nosebleeds
- Trouble swallowing
- Frequent sore throat/hoarseness
- Hearing loss/ringing in ears
- Runny nose/sinus congestion
- Change in vision/eye pain/redness
- Hay Fever/allergies
- No Problems**

Neck

- Neck pain/stiffness
- Neck swelling
- No Problems**

Respiratory

- Cough/Wheeze
- Loud snoring/altered breathing during sleep
- Short of breath/with exertion
- No Problems**

Breast

- Breast lump/pain/nipple discharge
- No Problems**

Cardiovascular

- Chest pain/discomfort
- Palpitations (fast or irregular heartbeat)
- No Problems**

Gastrointestinal

- Heartburn/reflux/indigestion
- Blood or change in bowel movement
- Constipation
- No Problems**

Genitourinary

- Leaking urine
- Blood in urine
- Nighttime urination or increased frequency
- Discharge: penis or vagina
- Concern with sexual function
- No Problems**

Female Only

- Pre-menstrual symptoms (bloating, cramps, irritability)
- Problems with menstrual periods
- Hot flashes/night sweats
- No Problems**

Musculoskeletal

- Back pain
- Muscle pain
- Joint pain
- No Problems**

Neurologic

- Headache
- Memory loss
- Fainting
- Numbness/tingling
- Unsteady gait
- Frequent falls
- No Problems**

Psychiatric

- Anxiety/stress/irritability
- Depression/sadness
- Sleep problem/insomnia
- Lack of concentration
- No Problems**

Endocrine

- Heat or cold sensitivity
- No Problems**

Hematologic/Lymphatic

- Swollen glands
- Easy bruising
- Easy bleeding
- Frequent infections
- No Problems**

Medical History: Please check all current medical conditions you have.

- | | |
|---|---|
| <input type="checkbox"/> Alcohol/Drug abuse | <input type="checkbox"/> Gynecologic Problems |
| <input type="checkbox"/> Allergies (Hay Fever) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hypertension/High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hip Fracture |
| <input type="checkbox"/> Bladder/Kidney Problems | <input type="checkbox"/> Other Fractures |
| <input type="checkbox"/> Blood Clot (Leg, Lung) | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Coronary Artery Disease (heart attack) | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes I (Childhood Onset) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes II (Adult Onset) | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Gastroesophageal Reflux (Heartburn/GERD) | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Gout | |

List Other Medical Conditions not included above:

Surgical History: Check all surgeries you have had and list year of the surgery.

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Knee Replacement (Right/Left/Both) (Yr____) |
| <input type="checkbox"/> Appendectomy (Yr____) | <input type="checkbox"/> Knee Arthroscopy (Right/Left/Both) (Yr____) |
| <input type="checkbox"/> Tonsilectomy/Adenoidectomy (Yr____) | <input type="checkbox"/> Shoulder Arthroscopy (Right/Left/Both) (Yr____) |
| <input type="checkbox"/> Cholecystectomy /Gallbladder (Yr____) | <input type="checkbox"/> Breast Biopsy (Right/Left/Both) (Yr____) |
| <input type="checkbox"/> Coronary Artery Bypass /CABG (Yr____) | <input type="checkbox"/> Back/Neck Surgery (Yr____) |
| <input type="checkbox"/> Hernia Repair (Yr____) | <input type="checkbox"/> Cataract (Right/Left/Both) (Yr____) |
| <input type="checkbox"/> Hysterectomy (total/partial) (Yr____) | <input type="checkbox"/> Tubal Ligation (Yr____) |
| <input type="checkbox"/> Hip Replacement (Right/Left/Both) (Yr____) | <input type="checkbox"/> Vasectomy (Yr____) |

List other surgeries:

Social History

Marital Status:(circle one) Single Married Divorced Widowed

Work Status:(circle one) Full-Time Part-Time Retired Unemployed Disabled Other:_____

Occupation:(current/prior)_____

Tobacco Use:

Do you currently smoke cigarettes, cigars, or a pipe? Yes No

If yes: How many packs per day? _____ How many years have you smoked? _____

If you currently do not smoke, have you ever smoked? Yes No

If yes: When did you quit (year)? _____

Prior to quitting, how many years did you smoke? _____

How many packs per day? _____

Do you use smokeless tobacco (chew, dip)? Yes No

If yes: How many years?_____ How much per day?_____

Alcohol Use:

Do you currently drink alcohol (beer, wine, liquor, spirits) on a regular basis? Yes No

If yes: How many drinks do you consume per week? _____

Have you ever had a problem with alcohol abuse? Yes No

Recreational Drug Use:

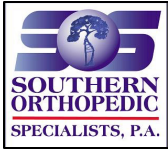
Do you currently use any recreational drugs (marijuana, cocaine, etc.) regularly? Yes No

If yes: What drug(s)? _____ How often?_____

Have you ever had a problem with substance/drug abuse? Yes No

If yes: When was the last time you used drugs? _____

Have you ever used needles to inject drugs? Yes No



Name: _____ Date of Birth ___/___/___ Date: ___/___/___

New Patient Health History

Reason For Visit

Main Reason for Today's Visit: _____

Other Concerns: _____

Current/Previous Primary Care Provider: _____

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If yes: When was the last time you used drugs? _____

Have you ever used needles to inject drugs? Yes No

Exercise: Do you currently exercise regularly? Yes No

If yes: How many times a week? (circle one) 1 2 3 4 5 6 7

What type of exercise? _____

Advance Directives: Do you currently have an Advanced Directive for Health Care (ADHC), Living Will, or Physician Orders for Life Sustaining Therapy (POLST)? Yes No

If yes: Which one? (circle all that apply): ADHC Living Will POLST

Health Maintenance

Have you ever had a colonoscopy? Yes No

If yes: When (year)? _____ Results? Normal Polyps Diverticulosis/itis Other:_____

Have you ever had a bone density scan (DXA scan)? Yes No

If yes: When (year)? _____ Results? Normal Osteopenia Osteoporosis Unknown

Immunizations: Are you up to date on your routine immunizations? Yes No Unknown

Last Flu Vaccine (year)? _____

Last Pneumonia Vaccine (year)? _____ Which? Prevnar 13 Pneumovax 23 Unknown

Last Tetanus Booster (Td or Tdap) (year)? _____

Have you had a Zostavax Vaccine (shingles)? Yes No If yes, when? _____

Females Only:

When was your last PAP smear? _____

Have you ever had an abnormal PAP smear? Yes No

If yes: When? _____ What was the abnormality? _____

When was your last mammogram? _____

Have you ever had an abnormal mammogram? Yes No

If yes: When? _____ What was the abnormality? _____