ORTHOPAEDIC ASSOCIATES
The Strength of Experience

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: _____	**Description of Injury/Accident**
☐ **Injury** ☐Accident ☐Sport Date of injury: _____	
☐ **Injury at Work** Date of injury: _____ ☐Lift ☐Twist ☐Fall ☐Bend ☐Pull ☐Reach ☐Repetitive	
☐ **Auto Accident** Date of 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.

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

List Other Medical Conditions not included above:

_____

_____

_____

_____

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

- ☐ None
- ☐ Appendectomy (Yr_____)
- ☐ Tonsilectomy/Adenoidectomy (Yr_____)
- ☐ Cholecystectomy /Gallbladder (Yr_____)
- ☐ Coronary Artery Bypass /CABG (Yr_____)
- ☐ Hernia Repair (Yr_____)
- ☐ Hysterectomy (total/partial) (Yr_____)
- ☐ Hip Replacement (Right/Left/Both) (Yr_____)
- ☐ Knee Replacement (Right/Left/Both) (Yr_____)
- ☐ Knee Arthroscopy (Right/Left/Both) (Yr_____)
- ☐ Shoulder Arthroscopy (Right/Left/Both) (Yr_____)
- ☐ Breast Biopsy (Right/Left/Both) (Yr_____)
- ☐ Back/Neck Surgery (Yr_____)
- ☐ Cataract (Right/Left/Both) (Yr_____)
- ☐ Tubal Ligation (Yr_____)
- ☐ Vasectomy (Yr_____)

List other surgeries:

_____

_____

_____

_____

Allergies: Check allergies that you have.

☐ No Known Medication Allergies
☐ Latex
☐ Shell Fish
☐ Bees/Wasps/other insects
☐ Peanuts/Chestnuts/other nuts
☐ Penicillin
☐ Flouroquinolones (Cipro, Levaquin)
☐ Aspirin
☐ NSAID's (anti-inflammatories)

List other allergies (medication and non-medication allergies):

_____

_____

_____

Medications

Prescription Medications: List all prescription medications that you take on a regular basis. (Use back of sheet for additional space if needed.)

Name of Medication	Dose	Frequency

Non-Prescription Medications: List all over-the-counter and herbal medications that you take on a regular basis. (Use back of sheet for additional space if needed.)

Name of Medication	Dose	Frequency

Family History: Indicate which relative has had the following diseases.

☐ Adopted and do not know biologic family history.

Disease	Mother	Father	Sister(s)	Brother(s)	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Other Relative	Comments
No significant history known										
Alzheimer's Dementia										
Asthma										
Autoimmune Disease										
Bleeding/Clotting Disorder										
Cancer - Breast										
Cancer - Colon										
Cancer - Lung										
Cancer - Prostate										
Cancer – Other (please indicate)										
Colon Polyps										
Coronary Artery Disease (heart attack)										
Other Heart Disease (specify)										
Depression/Anxiety										
Diabetes Type I (child onset)										
Diabetes Type II (adult onset)										
Emphysema (COPD)										
Hypertension (high blood pressure)										
High Cholesterol										
Hip Fracture										
Thyroid Disease										
Kidney Disease										
Macular Degeneration										
Osteoporosis										
Stroke										
Other (please list)										

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