ORA ORTHOPEDICS

Patient Name: _____ **Provider:** _____

Date of Birth: _____ **Chart #** _____ **Date:** _____

MEDICAL HISTORY FORM

Age: ____ **Sex**: ☐ F ☐ M **Primary Care Doctor's Name**: _____ **Did they evaluate this problem?** ☐ Y ☐ N

Dominant Hand: ☐ R ☐ L **Height:** _____ **Weight:**_____ **(ORA staff to fill out: P**_____**R**_____**Temp**_____ **BP** _____**)**

Who requested that you be seen here? ☐ Primary care provider ☐ Emergency room or urgent care provider ☐ yourself ☐ other

Your hospital preference? _____

What problem are you being seen for today? ☐ R ☐ L _____

_____

When did your problem start or what was the date of the injury? _____

Were you seen in the E.R. for this problem? ☐ Y ☐ N **Which E.R.?** _____ Date _____

What tests/treatments have you had for this problem? ☐ X-Rays ☐ MRI ☐ CT scan ☐ Bone scan ☐ Ultrasound
☐ Nerve Test (EMG/NCV) ☐ Physical Therapy ☐ Medications ☐ Previous surgery for this problem ☐ Other_____

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

Has your problem kept you from: ☐ Working ☐ Recreational activities ☐ Activities of daily living like cleaning & dressing yourself

I experience: ☐ Pain ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control bowel/bladder
☐ Locking ☐ Catching ☐ Instability ☐ Swelling ☐ Stiffness ☐ Other _____

If you have pain: How would you describe the type of pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

On a scale of 0 - 10 (10 is the worst) how <u>severe</u> is your pain? _____

The pain is: ☐ Constant ☐ Intermittent (comes & goes)

Does the pain radiate/travel/move? ☐ Y ☐ N If yes, where _____ _

Does your pain wake you from sleep? ☐ Y ☐ N

What makes your symptoms <u>worse</u>? ☐ Walking ☐ Stairs ☐ Exercising ☐ Twisting ☐ Kneeling ☐ Direct pressure
☐ Standing ☐ Sitting ☐ Lying flat ☐ Bending ☐ Lifting ☐ Coughing / sneezing

What makes your symptoms <u>better</u>? ☐ Rest/Not Moving ☐ Sitting ☐ Lying ☐ Standing ☐ Exercise/Movement ☐ Elevation
☐ Ice ☐ Heat ☐ Compression or bracing ☐ Injections ☐ Pain pills ☐ Other Meds

If there was a specific injury, please describe what happened:

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REVIEW OF SYSTEMS

Have you recently had any of these symptoms? Please ☑ check all that apply. **If none of the below apply, then mark ☐ NONE.**

Skin
- ☐ Frequent Rashes
- ☐ Open Wounds
- ☐ Itchy/Red

Eye
- ☐ Blurred Vision
- ☐ Vision Loss
- ☐ Double Vision

Lung
- ☐ Short of Breath
- ☐ Wheezing
- ☐ Chronic Cough

ENT
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Difficulty Swallowing

Digestive
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Blood in Stool

Blood
- ☐ Easy Bruising
- ☐ Easy Bleeding

Neuro
- ☐ Headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Frequent Falls

Glands
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Always Hot/cold
- ☐ Lymphedema

Kidney/Bladder
- ☐ Painful Urination
- ☐ Kidney Problems
- ☐ Urinary Infections

Bones/Joints
- ☐ Osteoporosis
- ☐ Joint Problems
- ☐ Broken Bones

Const
- ☐ Recent Weight Loss
- ☐ Frequent Fever
- ☐ Loss of Appetite

Cardio
- ☐ Chest Pain
- ☐ Irregular Beat
- ☐ Calf Pain
- ☐ Swelling Feet/Ankle

Psych
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Depression
- ☐ Anxiety

PAST MEDICAL HISTORY

List any other doctors and their specialty that you see:_____

Do you have a history of any of the following: (Please ☑ check all that apply)

Bones/Joints
- ☐ Broken
- ☐ Osteoporosis
- ☐ Arthritis

Heart
- ☐ Open Heart
- ☐ Stents
- ☐ Heart attack
- ☐ Pacemaker

Circulation
- ☐ Blood Clots
- ☐ Clotting Disorders
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Elevated Cholesterol

Current/Past Infection
- ☐ Pneumonia
- ☐ Hepatitis ☐A ☐B ☐C
- ☐ HIV/Aids
- ☐ MRSA
- ☐ VRE

Lung
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea

Glands
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Thyroid

Kidney
- ☐ Infection
- ☐ Stones

Neuro
- ☐ Neuropathy
- ☐ Seizures

Psych
- ☐ Anxiety
- ☐ Depression

Digestive
- ☐ Heartburn
- ☐ Reflux
- ☐ Ulcers
- ☐ Dialysis

Other
- ☐ Liver Disease
- ☐ Cancer
- ☐ _____

List <u>past surgeries</u> and what year that they occurred: ☐ **NONE** ☐ Appendectomy ☐ Tonsil ☐ Adenoids ☐ C-section ☐ Bypass ☐ Gall Bladder ☐ Tubes in Ear ☐ Hernia Repair ☐ Oral Surgery ☐ Hysterectomy ☐ Tubal Ligation ☐ Orthopedic Surgery ☐ Others:

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Current medications, the dose and frequency (list all prescription and over the counter medications / supplements):

☐ **NONE** ☐ **Please see list on separate sheet (please date the sheet and write your name on the sheet)**

Are you allergic to any medications? ☐ Y ☐ N If yes, please list below and list the reaction (hives/stopped breathing/rash/swelling):

☐ **Other Allergies:** ☐ Latex ☐ Food ☐ Seasonal ☐ Metal ☐ Other **Have you ever had a reaction to anesthesia?** ☐ Y ☐ N

FAMILY HISTORY

☐ Adopted and family medical history is not known ☐ No significant medical history of any direct relatives

List any major medical problems (examples: diabetes, heart disease, cancer, arthritis …) of your direct relatives:

Mother:_____ Father:_____

Grandparents: _____

Brothers/Sisters:_____ Children:_____

SOCIAL HISTORY

Do you use tobacco? ☐ No ☐ Quit ☐ Yes - How much? _____ **Alcohol use?** ☐ No ☐ Yes – How much? _____

Are you currently working? ☐ Y ☐ N **Type of job:** _____ ☐ Disabled ☐ Retired

Student at _____What grade level_____ Participating in what **sports**?_____

Marital Status: ☐ Single ☐ Married ☐ Widowed **Children:** ☐ Y ☐ N **Are you pregnant?** ☐ Y ☐ N ☐ Unknown

Patient Signature The information on this form is accurate to the best of my knowledge. **Date**

FOR OFFICE USE ONLY: (Initial and date when completed and with each update)

Review#1 by: Date Review #2 by: Date Form-#285