ORTHOPEDICS & SPORTS MEDICINE - MEDICAL HISTORY

OCCUPATION: _____

PRESENT CONDITION:

A. What is your chief complaint? (the reason you made your appointment)

_____

On what date did this occur? If there was no injury, for how long have you had these symptoms?

_____

Is this a work related injury? YES NO Is this injury related to an auto accident? YES NO

B. Please mark your primary complaint:

Loss of: ☐ Function ☐ Motion ☐ Strength

Pain with: ☐ Walking ☐ Sleeping ☐ Standing ☐ Sitting ☐ Sports ☐ Reaching ☐ Lifting ☐ Work duties

Other:_____

C. What makes your symptoms worse?

☐ Sitting ☐ Standing ☐ Bending ☐ Walking ☐ Reaching ☐ Other – please specify_____

D. Do you have numbness/tingling in the injured or affected body part? ☐ Yes ☐ No

If yes, where? _____

E. What eases your symptoms?

☐ Sitting ☐ Standing ☐ Ice ☐ Heat ☐ Rest ☐ Elevation ☐ Other – please specify_____

☐ Medication (please list) _____

F. What is the quality of your pain? ☐ Mild ☐ Moderate ☐ Severe

G. How would you describe your pain? ☐ Sharp ☐ Dull ☐ Burning ☐ Aching

☐ Radiating – if checked, indicate where: _____

H. What symptoms are associated with your complaint?

☐ Swelling ☐ Locking ☐ Popping ☐ Grinding ☐ Redness ☐ Fever ☐ Weakness ☐ Loss of range of motion

☐ Instability ☐ Dislocation ☐ Other _____

I. What tests have been performed? ☐ X-ray ☐ MRI ☐ EMG ☐ CT ☐ Bone scan ☐ Other_____

J. Have you received any injections for these symptoms? ☐ YES ☐ NO

IF YES: Date of injection: _____ Location of injection (body part): _____

The injection provided: ☐ Good relief – for how long? _____ ☐ Some relief – for how long? _____ ☐ No relief

K. Have you had physical/occupational therapy for your symptoms/injury? ☐ YES ☐ NO

IF YES: How long did you receive physical therapy (date range)? _____

L. How much do your symptoms interfere with your activities?

Daily Activities of Living: ☐ None ☐ Rarely ☐ Often ☐ Most of the time ☐ Always

Recreational Activities: ☐ None ☐ Rarely ☐ Often ☐ Most of the time ☐ Always

PLEASE CHECK IF YOU ARE CURRENTLY:

☐ Reside in a Skilled Nursing Facility or Nursing Home.

If yes, please list the name of the facility: _____

☐ Receiving Home Health Services (Nursing, household chore assistance, physical therapy, etc…)

If yes, please list the name of the facility: _____

PRIMARY CARE PROVIDER: _____

Please List All Medications You Are Taking (including non-prescription)

_____ _____

_____ _____

_____ _____

ALLERGIES-(please fill in the boxes that apply)

☐None ☐Codeine ☐Fentanyl ☐Penicillin ☐Propofol/Diprivan ☐IV Contrast Dye ☐Eggs ☐Aspirin ☐Demerol ☐Morphine ☐Sulfa ☐Versed ☐Latex ☐Methimazole ☐Propylthiouracil

☐Other_____

ARE YOU ON ANY OF THE FOLLOWING BLOOD THINNERS? (CHECK ALL THOSE THAT APPLY)

☐ ASPIRIN ☐ PLAVIX ☐ EFFIENT ☐ AGGRENOX ☐ WARGARIN/COUMADIN ☐ PRADAXA ☐ XARELTO

☐ OTHER: _____

FAMILY HISTORY (please list which member):

	Mother	Father	Bro.	Sis.	Grandparents
Bone/Joint/Ligament Disease	_____	_____	_____	_____	_____
Genetic Disorder	_____	_____	_____	_____	_____
Colon Cancer/Polyps:	_____	_____	_____	_____	_____
Breast Cancer:	_____	_____	_____	_____	_____
Heart Disease:	_____	_____	_____	_____	_____
Liver Disease:	_____	_____	_____	_____	_____
Kidney Disease:	_____	_____	_____	_____	_____
Thyroid Disorder:	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

SOCIAL HISTORY:

MARITAL STATUS:
☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Separated
☐ Same-Sex Partner

ALCOHOL HISTORY:
☐ Never
☐ Occasional
☐ Less than 7 drinks/day
☐ More than 7 drinks/day
☐ Quit alcohol

CAFFEINE INTAKE:
☐ Never
☐ Occasional
☐ Less than 7 drinks/day
☐ More than 7 drinks/day

EXERCISE:
☐ Never
☐ Less than 3 days/week
☐ 3-7 days/week

RECREATIONAL DRUGS:
☐ Never
☐ In the past
☐ Currently using
☐ In treatment

TOBACCO STATUS (Smoking):
☐ Never
☐ Quit tobacco
☐ Less than 1 pack/day
☐ 1 pack/day ☐ 2-4 pack/day

Age started: _____
Years used: _____
Chewing:
☐ Never
☐5+ pack/day

PAST SURGICAL HISTORY (please put date by procedure):

_____
_____
_____

PAST MEDICAL ILLNESSES-(please circle those that apply)

AIDS/HIV
Abdominal Pain
Abuse/Domestic Violence
Anemia
Anesthesia Complications
Aneurysm
Anxiety Disorder
Arthritis
Asthma
Atrial Fibrillation
Autoimmune Disorder
Bleeding Disorder
Blood Diseases
Blood Transfusion
Cancer
Carpal Tunnel Disorder
CHF-Congestive Heart Failure
Coronary Artery Disease
DVT
Degenerative Joint Disease
Degenerative Disc Disease
Depression
Diabetes
Diabetic Retinopathy
Emphysema/COPD
Encephalitis
Fibromyalgia
Heart Attack
Heart Disease/Heart Problems
Hepatitis
High Blood Pressure
High Cholesterol
Hypercalcemia
Hyperlipidemia
Hypertensive Cardiovascular Disease
Hyperthyroidism
Hypothyroidism
Irritable Bowel Syndrome
Ischemic Neurologic Deficit
Kidney Disease
Kidney Stones
Liver Disease
Lung Disease
Lupus
Obesity
Obstructive Sleep Apnea
Osteoporosis
Other: _____
_____
Pancreatitis
Peripheral Vascular Disease
Post Menopause
Prostate Disease
Rheumatoid Arthritis
Seizure/Epilepsy
Sleep Apnea
Stroke
Thyroid Disease
Ulcer

RECENT SYMPTOMS-(please check current problems)

CONSTITUTIONAL: ☐ Fever ☐ Diminished Activity ☐ Fatigue
MUSCULOSKELETAL: ☐ Soft Tissue Swelling ☐ Joint Swelling ☐ Myalgia ☐ Limited Motion ☐ Previous Injuries ☐ Trauma
RESPIRATORY: ☐ Cough ☐ Bark-like cough ☐ Wheezing ☐ Chest Tightness ☐ Pain with Respiration ☐ Noisy Breathing ☐ Rapid Respirations ☐ Difficulty Breathing
SKIN: ☐ Pain ☐ Itchiness ☐ Dry Skin ☐ Flaking ☐ Redness ☐ Rash ☐ Hives ☐ Skin Lesions ☐ Bruising ☐ Insect Bites
NEUROLOGIC: ☐ Numbness ☐ Weakness ☐ Tingling ☐ Burning ☐ Shooting Pain ☐ Dizziness ☐ Loss of Consciousness