Health History - Orthopedics

Name: _____ **DOB:** _____
Preferred Name (Nickname): **Pharmacy**
Name: _____ **Pharmacy Address:** _____
PCP/Referring Provider Name: _____
List of all doctors you see (Care Team): _____

Reason for today's visit: _____
When did your symptoms begin? _____
What triggers your symptoms? _____
What makes your symptoms better? _____
Grade your pain 0-10 (0= no pain and 10=worst pain): 10 = worst pain
What treatment have you had for your symptoms? _____
Affected Side: ☐ Left ☐ Right ☐ Both
Body Area: ☐ Knee ☐ Shoulder ☐ Hip ☐ Ankle ☐ Elbow ☐ Foot ☐ Hand ☐ Wrist ☐ Spine
☐ Other: _____

Is your problem getting: ☐ Worse ☐ Better ☐ Staying the same

What studies have you done? ☐ CT ☐ MRI ☐ Bone Scan ☐ Other_____

Have you had injections? ☐ Yes ☐ No

If so, where: _____
How much did it help? _____
For how long? _____
Any additional complaints? _____

Was this a result of an injury? ☐ Yes ☐ No

If yes, please complete the following questions:

What type of injury? ☐ Auto ☐ Worker's Compensation ☐ Other

Date of Injury: _____

Describe how it happened? _____

If injured, is litigation ongoing? ☐ Yes ☐ No

Are you: ☐ Off Work ☐ Modified Duty ☐ Full Duty

ALLERGIES List all allergies to medications or foods and your reaction:

ALLERGY	REACTION

MEDICATIONS Please list all medicines you are currently taking (include over the counter such as vitamins):

NAME OF MEDICATION	DOSAGE	HOW OFTEN PER DAY

FAMILY HISTORY Please list any relative with the following medical problems and their relationship to you:

	Relation		Relation
☐ Aneurysm		☐ Heart Disease	
☐ Arthritis		☐ History of Emphysema	
☐ Back Problem		☐ Multiple Sclerosis	
☐ Blood Clotting Disorder		☐ Osteoporosis	
☐ Deep Venous Thrombosis		☐ Parkinson's Disease	
☐ Diabetes Mellitus		☐ Rheumatoid Arthritis	
☐ Family History of Cancer		☐ Substance Abuse	
☐ Gout			

SOCIAL HISTORY

Tobacco Use	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long? _____ Year Quit: _____ ☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/day
Live alone or with others?	☐ Alone ☐ With others
Employment	Occupation: Employer:
Single or Multi-level home/work	☐ Single Level Home ☐ Multi-Level Home ☐ Single Level Work ☐ Multi-Level Work
Able to care for self ?	☐ Yes ☐ No
Hand dominance	☐ Right ☐ Left ☐ Bilateral
Sports Activities	
General Stress Level	☐ Low ☐ Medium ☐ High
Exercise Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Diet	☐ Regular ☐ Vegetarian ☐ Gluten Free ☐ Carbohydrate ☐ Cardiac ☐ Diabetic
Caffeine Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day _____
Alcohol Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? ____
Is blood transfusion acceptable in an emergency?	☐ Yes ☐ No
Advance directive?	☐ Yes ☐ No

PAST SURGICAL HISTORY Have you ever had the following:

	Year		Year		Year
☐ Achilles Tendon Repair		☐ Device Implant		☐ Knee Surgery	
☐ Amputation		☐ Elbow Surgery		☐ Lumbar Spine Surgery	
☐ Ankle/Foot Surgery		☐ Fem Fem Bypass		☐ Open Reduction Internal Fixation	
☐ Arthroscopic Surgery		☐ Fem Pop Bypass		☐ Orthopedic Surgery	
☐ Arthroscopic/Knee		☐ Fem Tib Bypass		☐ Popliteal Artery Stent	
☐ Axillo-Fem Bypass		☐ Fracture Surgery		☐ Popliteal Balloon Angioplasty	
☐ Back Surgery		☐ Hand Surgery		☐ Popliteal Tibial Bypass	
☐ Bone Marrow		☐ Hip Replacement		☐ Shoulder Surgery	
☐ Cancer Surgery		☐ Hip Surgery		☐ Spine Surgery	
☐ Carpal Tunnel Syndrome		☐ Joint Replacement		☐ Other:	
☐ Cervical Spine Surgery		☐ Knee Replacement			

Any other Medical/Surgical history/conditions, please inform the nurse.

PAST MEDICAL HISTORY Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

	Yes	No		Yes	No
Allergies	☐	☐	Headaches/Migraine	☐	☐
Anemia	☐	☐	Hearing Loss	☐	☐
Arthritis Rheumatoid	☐	☐	Heart Disease	☐	☐
Arthritis Osteoarthritis	☐	☐	Heart Rhythm Disorder	☐	☐
Asthma	☐	☐	Hyperlipidemia	☐	☐
Autoimmune Disease	☐	☐	Kidney Disease/Stones	☐	☐
Back/Neck Pain	☐	☐	Liver Disease/Hepatitis	☐	☐
Bleeding Disorder/DVT	☐	☐	Lung Disease	☐	☐
Blood Disorder	☐	☐	Mental Illness	☐	☐
Bowel Disease	☐	☐	Movement Disorder	☐	☐
Coronary Artery Disease	☐	☐	Nerve Disease	☐	☐
Congestive Heart Failure	☐	☐	Osteopenia/Osteoporosis	☐	☐
COPD	☐	☐	Overweight/Obesity	☐	☐
Dementia	☐	☐	Pneumonia	☐	☐
Depression	☐	☐	Prostate Disorder	☐	☐
Developmental Disorder	☐	☐	Spine Disease	☐	☐
Diabetes Type 1	☐	☐	Stroke/TIA	☐	☐
Diabetes Type 2	☐	☐	Thyroid Disease	☐	☐
Diabetic Complications	☐	☐	Tuberculosis or + TB test	☐	☐
Endocrine Disease	☐	☐	Urinary Problem	☐	☐
Eye Problems	☐	☐	Viral Disease	☐	☐
Fibromyalgia/Pain Disorder	☐	☐	Other:	☐	☐
Gastritis/Ulcer	☐	☐			
GERD/Acid Reflux	☐	☐			

Review of Systems

Check all that apply:

Constitutional

- ☐ Yes ☐ No Recent Weight Change
- ☐ Yes ☐ No Decreased Appetite
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Sweats
- ☐ Yes ☐ No Fatigue

Head

- ☐ Yes ☐ No Headaches

Eyes

- ☐ Yes ☐ No Vision Changes
- ☐ Yes ☐ No Eye Disease/Injury

ENMT

- ☐ Yes ☐ No Difficulty Hearing/Ringing
- ☐ Yes ☐ No Sinus Pain
- ☐ Yes ☐ No Nosebleeds
- ☐ Yes ☐ No Nasal Discharge
- ☐ Yes ☐ No Teeth/Gum Problems

Cardiovascular

- ☐ Yes ☐ No Heart Trouble
- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Palpitations
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Swelling of Feet/ Ankles/Hands
- ☐ Yes ☐ No High Blood Pressure

Breast/Chest

- ☐ Yes ☐ No Breast Pain
- ☐ Yes ☐ No Breast Mass/Lump
- ☐ Yes ☐ No Nipple Discharge

Respiratory

- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Difficulty Breathing

Gastrointestinal

- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No Appetite Changes
- ☐ Yes ☐ No Change in Bowel Movement
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Rectal Bleeding
- ☐ Yes ☐ No Stomach Ulcer

Genitourinary

- ☐ Yes ☐ No Kidney Disease

Musculoskeletal

- ☐ Yes ☐ No Muscle Pain
- ☐ Yes ☐ No Joint Pain

Integumentary

- ☐ Yes ☐ No Rash/Mole Change
- ☐ Yes ☐ No Itching/Rash
- ☐ Yes ☐ No Change in Hair/Nails
- ☐ Yes ☐ No Change in Skin Color
- ☐ Yes ☐ No Varicose Veins

Neurologic

- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Dizziness or Lightheadedness
- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Memory Loss
- ☐ Yes ☐ No Loss of Coordination

Heme/Immunology

- ☐ Yes ☐ No Slow to Heal After Cuts
- ☐ Yes ☐ No Bleeding/Bruising Tendency
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Blood Clots
- ☐ Yes ☐ No Blood Transfusion
- ☐ Yes ☐ No Enlarged Glands

Allergic/Immunologic

- ☐ Yes ☐ No HIV

Skin Reaction or Other Adverse Reaction to:

- ☐ Yes ☐ No Penicillin/Antibiotics
- ☐ Yes ☐ No Morphine/Demerol Other Narcotics

Endocrine

- ☐ Yes ☐ No Glandular/Hormone Problem
- ☐ Yes ☐ No Thyroid Disease
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Excessive Urination

Psychiatric

- ☐ Yes ☐ No Problems with Sleep
- ☐ Yes ☐ No Memory Loss/Confusion