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Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

What is your email address? _____

Reason for today's visit: _____

_____

_____

Type of problem

pain ○	sprain / strain ○	weakness ○			
fracture (broken bone) ○	swelling (new) ○	numbness / tingling ○	other ○		

Location of your injury / condition

	right	left	bilateral		right	left	bilateral
collar bone	○	○	○	hip	○	○	○
shoulder	○	○	○	thigh	○	○	○
upper arm	○	○	○	knee	○	○	○
elbow	○	○	○	lower leg	○	○	○
lower arm	○	○	○	ankle	○	○	○
wrist	○	○	○	foot	○	○	○
hand	○	○	○	toes	○	○	○
fingers	○	○	○	back pain	○	○	○
pelvis	○	○	○	neck pain	○	○	○

○ other _____

PAIN INFORMATION

Is the pain:	occasional ○	continuous ○	n/a ○		
Is the pain:	improving ○	worsening ○	unchanged ○	comes and goes ○	n/a ○
Is the pain:	sharp ○	dull ○	radiating ○	n/a ○	

What time of day is your pain worse?

morning ○	afternoon ○	evening ○	night time ○	all day ○	n/a ○

Do you wake up at night with this pain? yes ○ no ○

What makes your pain BETTER? (Mark all that apply)

medication ○	exercise ○	sitting ○	rest ○	elevation ○
walking ○	standing ○		heat ○	n/a ○
physical therapy ○	massage ○			
ice ○	sleeping ○	○ other_____		

What makes your pain WORSE? (Mark all that apply)

employment / work ○	running ○	squatting ○	bending ○	kneeling ○
sitting for long periods of time ○	driving ○			n/a ○
standing for long periods of time ○	walking ○			
weather ○	sleeping ○	○ other_____		

INJURY CONDITION

Date of onset: _____

How did it happen? _____

_____

_____

Where did it happen?	home ○	work ○	public ○	auto ○	school ○	other ○
Are you claiming this as work related?		yes ○	no ○			
Was this the result of an injury?		yes ○	no ○			

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PREVIOUS TREATMENT

Have you been seen by any other doctor for this injury / condition? yes ◯ no ◯

If yes, which type of doctor did you see?
ortho ◯ family MD ◯ occ med ◯ chiropractor ◯ other ◯

When did you see the other doctor? (If applicable)
in last month ◯ 1-3 months ◯ 3-6 months ◯ 6-12 months ◯ over 1 year ◯

Have you had any of the following for this problem? (Mark all that apply)
x-rays ◯ CT ◯ MRI ◯ bone scan ◯ other ◯ **NONE** ◯

Have you received any of the following treatments? (Mark all that apply. If none, mark "**NONE**.")

injection ◯	**If yes, did it help?**	yes ◯	no ◯
medications ◯	**If yes, did it help?**	yes ◯	no ◯
physical therapy ◯	**If yes, did it help?**	yes ◯	no ◯
surgery ◯	**If yes, did it help?**	yes ◯	no ◯
NONE ◯			

Have you had any previous difficulty or injury to this area? yes ◯ no ◯

If yes, please describe:_____

SOCIAL HISTORY

What is your occupation? _____

What is your marital status?
single ◯ married ◯ divorced ◯ separated ◯ widowed ◯

Who are you living with? (Mark all that apply)
spouse / partner ◯ parents ◯ siblings ◯ nursing home ◯
alone ◯ friends ◯ children ◯ retirement community ◯

How many children do you have? 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5+ ◯

I have had a flu shot in the last 12 months. yes ◯ no ◯

I am 65 years or older and have had a pneumonia vaccine. yes ◯ no ◯ n/a (under 65) ◯

Please indicate if you have a pacemaker, hearing aid, or metal in your body. (If you have none of these, mark "**NONE**.")
pacemaker ◯ hearing aid ◯ metal ◯ **If yes, where?** _____ **NONE** ◯

Are you exposed to passive (secondhand) smoke? yes ◯ yes, outdoors only ◯ no ◯

Please describe your cigarette smoking status.
currently (every day) ◯ currently (some days) ◯ in the past ◯ never ◯

I acknowledge that currently I am a smoker, and my orthopaedic provider strongly suggests I quit smoking.
I have read this suggestion from my orthopaedic provider. Please mark here to indicate: ◯

If you do smoke, how many packs per day? (If you smoked in the past, please include number you previously smoked.)
½ ◯ 1 ◯ 1 ½ ◯ 2 ◯ >2 ◯

Do you drink alcohol? yes ◯ no ◯ in the past ◯

If yes, how many drinks per week? occasionally ◯ 1-3 ◯ 4-7 ◯ 8-14 ◯ >14 ◯

Do you exercise? yes ◯ no ◯

If yes, how often? 1-3 times per week ◯ 3-5 times per week ◯ daily ◯

MEDICAL HISTORY

Please indicate if you have any of the following. (If none, mark "**NONE**.")

anesthesia problems ◯	seizure disorder ◯	Parkinson's ◯
arthritis ◯	hepatitis ◯	rheumatoid arthritis ◯
MS (multiple sclerosis) ◯	high blood pressure ◯	thyroid disease ◯
anemia ◯	high cholesterol ◯	GERD / heartburn ◯
asthma ◯	reflux ◯	HIV ◯
birth defect ◯	kidney disease ◯	mitral valve prolapse ◯
bleeding disease ◯	osteoporosis ◯	stroke ◯
depression ◯	fibromyalgia ◯	polio ◯
blood clots ◯	TB (tuberculosis) ◯	neurological disease ◯
bruise easily ◯	COPD / emphysema ◯	other connective tissue disorder ◯
heart disease / heart attack ◯	lupus ◯	other illness ◯
diabetes ◯	stomach ulcers ◯	**NONE** ◯

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Patient History

Please answer every question.

MEDICAL HISTORY (continued)

Please indicate if you have had any of the following cancers. (If none, mark "**NONE**.")

brain ◯	liver ◯	stomach ◯
breast ◯	ovarian ◯	other cancer ◯
colon / rectal ◯	prostate ◯	
lung ◯	skin ◯	**NONE** ◯

Please indicate if your PARENTS or GRANDPARENTS have had any of the following. (If none, mark "**NONE**.")

anesthesia problems ◯	arthritis ◯	
bleeding disease ◯	heart disease ◯	**NONE** ◯

SURGERIES

Please indicate if you have had any of the following surgeries:

◯ I have had **NO SURGERIES**. (If you have had no surgeries, please skip ahead to next section.)

tonsillectomy ◯	heart valve replacement ◯	sinus ◯	ulcer ◯
appendectomy ◯	carotid artery ◯	neck disc ◯	vasectomy ◯
hemorrhoidectomy ◯	hernia ◯	lower back disc ◯	other surgery ◯
heart bypass ◯	thyroid ◯	tubal ligation ◯	

cesarean section	1 ◯	2 ◯	3 or more ◯
gallbladder	open ◯	laparoscopic ◯	
colon removal	partial ◯	total ◯	
kidney removal	left ◯	right ◯	both ◯
D&C	single ◯	multiple ◯	
foot	left ◯	right ◯	both ◯
cataract	left ◯	right ◯	both ◯
breast cancer lump removal	left ◯	right ◯	both ◯
mastectomy	left ◯	right ◯	both ◯
breast reconstruction	left ◯	right ◯	both ◯
breast biopsy	left ◯	right ◯	both ◯
other breast surgery	left ◯	right ◯	both ◯
hysterectomy	partial ◯	total ◯	
ovary removal	left ◯	right ◯	both ◯
leg circulation	single ◯	multiple ◯	
prostate surgery	TURP ◯	removal ◯	
lung	left ◯	right ◯	
carpal tunnel	left ◯	right ◯	both ◯
rotator cuff repair	left ◯	right ◯	both ◯
arthroscopic shoulder	left ◯	right ◯	both ◯
hip fracture & surgery	left ◯	right ◯	both ◯
total hip replacement	left ◯	right ◯	both ◯
total knee replacement	left ◯	right ◯	both ◯
arthroscopic knee	left ◯	right ◯	both ◯
spinal fusion	neck ◯	lower back ◯	
spinal decompression	neck ◯	lower back ◯	
ulnar nerve	left ◯	right ◯	both ◯
hand	left ◯	right ◯	both ◯
other ◯	_____		

REVIEW OF SYSTEMS

Please indicate if you CURRENTLY are experiencing any of the following. (If none, mark "**NONE**.")

GENERAL			appetite loss ◯
	sweats ◯	fevers ◯	fatigue (always tired) ◯
	chills ◯	weight loss ◯	**NONE** ◯
EYES	eye irritation ◯	vision loss – 1 eye ◯	discharge ◯
	blurring ◯	vision loss – both eyes ◯	**NONE** ◯

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REVIEW OF SYSTEMS (continued)

EARS / NOSE / THROAT		
decreased hearing ○	difficulty swallowing ○	NONE ○
CARDIOVASCULAR		
chest pain or discomfort ○	weight gain ○	difficulty breathing while lying down ○
swelling of hands or feet ○	blackouts / fainting ○	shortness of breath with exertions ○
palpitations ○	racing / skipping heartbeats ○	NONE ○
RESPIRATORY		
shortness of breath ○	wheezing ○	coughing up blood ○
cough ○	chest discomfort ○	NONE ○
GASTROINTESTINAL	diarrhea ○	nausea ○
vomiting ○	loss of appetite ○	NONE ○
GENITOURINARY		
urinary retention ○	frequent UTI ○	pain ○
urinary urgency ○	urinary frequency ○	NONE ○
MUSCULOSKELETAL		
	joint pain ○	muscle cramps ○
joint swelling ○	back pain ○	muscle weakness ○
stiffness ○	arthritis ○	loss of strength ○
gout ○	muscle aches ○	NONE ○
SKIN	psoriasis ○	changes in nail beds ○
suspicious lesions ○	dryness ○	unusual hair distribution ○
poor wound healing ○	changes in color of skin ○	NONE ○
NEUROLOGIC		disturbances in coordination ○
headaches ○	numbness ○	falling down ○
weakness ○	tingling ○	visual disturbances ○
fainting ○	seizures ○	memory loss ○
poor balance ○	tremors ○	NONE ○
PSYCHIATRIC anxiety ○	depression ○	NONE ○
HEME / LYMPHATIC ○	abnormal bruising ○	NONE ○
ALLERGIC / IMMUNOLOGIC		
seasonal allergies ○	persistent infections ○	NONE ○

ALLERGIES AND MEDICATIONS

Mark here if you have no known medical allergies: ○

Are you allergic to any of the following? (Please list any reaction(s) you have.)

latex ○ _____
PCN ○ _____
betadine ○ _____
sulfa ○ _____
metal(s) ○ _____
other ○ _____

What is your preferred pharmacy? _____

Mark here if you take no regular medications: ○

Please list all medications you are currently taking. Include prescriptions, over-the-counter medications and vitamins.

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency