Premier ORTHOPAEDICS

MEDICAL HISTORY FORM (please complete in BLACK ink)

HISTORY OF PRESENT ILLNESS/INJURY

Name:_____ DOB:_____ Age:_____ Date:_____

Referred by: _____ Onset/Date of Injury: _____

Body Part(s): _____ □ Right □ Left □ Bilateral (both sides)

Height: _____ Weight: _____

Did this occur suddenly or gradually? _____

Complaint: □ Pain □ Numbness □ Swelling □ Weakness □ Other: _____

Severity:
□ Mild
□ Mild/Moderate
□ Moderate
□ Moderate/Severe
□ Severe

Status:
□ Unchanged
□ Better
□ Fluctuating
□ Improving
□ Worse
□ Resolved

Frequency:
□ Intermittent
□ Occasional
□ Constant
□ Rare

Quality:
□ Aching
□ Burning
□ Dull
□ Sharp
□ Throbbing

Context: □ Injury □ Sports Injury □ MVA □ Work Injury □ Other _____

Are you experiencing radiating pain? □ Yes □ No If "yes", where does the pain radiate to: _____

Aggravated by:
□ Bending
□ Climbing Stairs
□ Descending Stairs
□ Lifting
□ Movement
□ Pushing
□ Sitting
□ Standing
□ Walking
□ Other: _____

Relieved by:
□ Brace/Splint
□ Elevation
□ Exercise
□ Heat
□ Ice
□ Injection
□ Massage
□ Pain/Rx Meds: _____
□ Mobility
□ OTC Meds: _____
□ PT
□ Rest
□ Stretching
□ Other: _____

Associated Symptoms/Pertinent Negatives:
□ Bruising
□ Crepitus (cracking sounds)
□ Decreased Mobility
□ Difficulty going to sleep
□ Instability
□ Limping
□ Locking
□ Night Pain
□ Night-time awakening
□ Numbness
□ Popping
□ Spasms
□ Swelling
□ Tingling in the arms
□ Tingling in the legs
□ Tenderness
□ Weakness
□ Other _____

Have you had similar symptoms before? □ Yes □ No If "yes", when _____

Doctors who have treated you for this problem: _____

Did that doctor refer you here? □ Yes □ No

Please list all diagnostic tests and treatment performed elsewhere for today's problem (please provide When/Where/What):

_____

_____

_____

REVIEW OF SYSTEMS (Do you have any of the following symptoms? (Please check all that apply.)

Constitutional:
□ Fatigue
□ Fever

Metabolic/Endocrine:
□ Cold Intolerant
□ Heat Intolerant

Neurological:
□ Seizure
□ Dizziness
□ Poor Coordination

Immunological:
□Environment Allergies
□ Food Allergies

HEENT:
□ Headache
□ Vision Loss

Hematologic/Blood:
□ Bleeding

Respiratory:
□ Cough
□ Dyspnea (shortness of breath)

Cardiovascular:
□ Chest Pain
□ Cyanosis (blue coloration of skin)
□ Irregular Heartbeats/Palpitations

Integumentary/Skin:
□ Rash
□ Lesion/Wound

Gastrointestinal:
□ Constipation
□ Diarrhea
□ Nausea
□ Vomiting

Genitourinary:
□ Dysuria (painful urination)
□ Hematuria (blood in the urine)

□ **None of the above**

Current Medications: □ **NONE** □ **List attached**
_____
_____
_____

Allergies/Reactions: □ **NONE**
_____ / _____
_____ / _____
_____ / _____

Do you have a history of infection with a bacteria called MRSA? □ Yes □ No Date treated: _____

PATIENT'S MEDICAL HISTORY (Please check all that apply)

□ Alcoholism
□ Alzheimers
□Anemia
□ Angina
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Benign Prostatic Hypertrophy
□ Cancer
□ Cerebrovascular Accident (Stroke)
□ Congestive Heart Failure (CHF)
□ COPD (Emphysema)
□ Coronary Artery Disease
□ Crohn's Disease
□ Degenerative Joint Disease
□ Depression
□ Diabetes
□ Drug Abuse
□ DVT (Blood Clot)
□ Fibromyalgia
□ Gallbladder Disease
□ GERD
□ Gout
□ Hepatitis
□ Hyperlipidemia
□ Hypertension
□ Inflammatory Bowel Disease
□ Juvenile Rheumatoid Arthritis
□Kidney Disease
□Liver Disease
□ Lyme Disease
□ Migraine Headaches
□ Multiple Sclerosis
□ Myocardial Infarction (heart attack)
□ Obesity
□ Osteoarthritis
□ Osteoporosis
□ Parkinson Disease
□ Peptic Ulcer Disease
□ Psoriasis
□ PVD
□ Renal Disease
□ Rheumatoid Arthritis
□ Scoliosis
□ Seizure Disorder
□ Sleep Apnea
□ SLE (Lupus)
□ Spinal Stenosis
□ Thyroid Disease
□ Valvular Disease
□ **None**
□ **Other**:

PAST SURGICAL HISTORY □ **No Prior Surgery**

Operation (please verify what side of the body when necessary)	**DATE**

PATIENT'S FAMILY HISTORY

Heart Disease □ Yes □ No **Cancer** □ Yes □ No **Diabetes** □ Yes □ No
Rheumatologic/Gout Disorders □ Yes □ No **Bleeding Disorders** □ Yes □ No **History of Blood Clots** □ Yes □ No
Family history of chronic/inherited diseases: _____
Is your father living □ Yes □ No | **Is your mother living** □ Yes □ No
If no, cause of death(s) : _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: □ Yes □ No □ Former/Year Quit _____ **Consume Alcohol:** □ Yes □ No □ Former/Year Quit _____
Substance Abuse: □ Yes □ No □ Former/Year Quit _____
Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: _____
Hand Dominance: □ Left □ Right □ Ambidextrous
Occupation: _____ **Employment Status**: □ Full Time □ Part Time □ Unemployed □ Unable to work □ Light Duty

Date: _____ **Signature of Patient, Parent, or Guardian:** _____

Date: _____ **Reviewing Physician Signature:** _____