General Patient History

422

Medical Record Number

Date of Visit ☐☐ / ☐☐ / ☐☐☐☐

First Name

Middle

Last Name Suffix ○ Sr. ○ Jr. ○ III ○ IV ○ M.D. ○ PhD

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
month day year (4 digit ex. 1922)

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Gender
○ Female ○ Male

Race

○ African American ○ Asian ○ Caucasian ○ Hispanic ○ Native American ○ Other_____

Marital Status

○ Single ○ Married ○ Living with significant other ○ Divorced ○ Separated ○ Widowed

Location of Injury or Problem

☐ Right Ankle/Foot	☐ Right Hand
☐ Left Ankle/Foot	☐ Left Hand
☐ Right Knee	☐ Right Wrist
☐ Left Knee	☐ Left Wrist
☐ Right Leg (not knee or foot)	☐ Right Elbow
☐ Left Leg (not knee or foot)	☐ Left Elbow
☐ Right Hip	☐ Right Shoulder
☐ Left Hip	☐ Left Shoulder
☐ Low Back	☐ Neck

Location of Worst Problem (if you are seeing us for more than 1 problem)

○ Right Ankle/Foot	○ Right Hand
○ Left Ankle/Foot	○ Left Hand
○ Right Knee	○ Right Wrist
○ Left Knee	○ Left Wrist
○ Right Leg (not knee or foot)	○ Right Elbow
○ Left Leg (not knee or foot)	○ Left Elbow
○ Right Hip	○ Right Shoulder
○ Left Hip	○ Left Shoulder
○ Low Back	○ Neck

Please describe your current problem? (If you are seeing the doctor for multiple problems, answer for the most severe)

○ New Injury or problem (less than 3 months duration)
○ Subacute problem (began slowly with no identifiable cause and progressively worsened)
○ Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
○ Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure) ☐☐ / ☐☐ / ☐☐☐☐
month day year

Date of re-injury ☐☐ / ☐☐ / ☐☐☐☐
month day year

Is your problem a result of an injury? ○ Yes ○ No

ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY

If your problem is the result of an injury, where did it occur? (check one answer only)

○ Home ○ Work ○ Motor vehicle accident ○ Exercise ○ Sport Competition ○ Other (specify)_____

What caused your injury?

☐ Fall	☐ Fighting
☐ Lifting	☐ Twisting
☐ Throwing	☐ Collision/Contact
☐ Reaching	☐ Other (specify)_____
☐ Pulling	

Check any of the following that happened at the time of your injury

☐ Felt pain ☐ Heard popping ☐ Had swelling ☐ Dislocation ☐ Fracture ☐ Other (specify)_____

Have you talked to a lawyer concerning your injury? ○ Yes ○ No

Are you receiving or have you applied for workers compensation concerning your injury? ○ Yes ○ No

Have you received previous treatment for your current problem? ○ Yes ○ No

*If yes, please specify treatment type **(check all that apply)** and provide the **# of the procedures** or **weeks of physical therapy** you have had for the specific problem you are seeing the doctor for today*

☐ ER Visit	☐ chiropractic
☐ oral medicine	☐ massage therapy
☐ physical therapy # of weeks ☐☐	☐ acupuncture
☐ surgical # of surgeries ☐☐	☐ other_____ (specify)
☐ injections # of injections ☐☐	

Please tell us your height and weight Height ☐ ft ☐☐ inches Weight ☐☐☐ pounds

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Physician You are Seeing Today (write only first and last name, do not write "Dr.")

Referring Physician (write only first and last name, do not write "Dr.")

Review of Systems

Please check all problems you currently experience - You may check more than one answer for each category.
If a problem does not apply to you DO NOT put any marks in the box.

☐ **Check this box if none of the following symptoms apply to you TODAY**

Overall General Health
- ☐ recent weight gain
- ☐ recent weight loss
- ☐ appetite change
- ☐ difficulty sleeping

Endocrine & Metabolic
- ☐ sugar diabetes
- ☐ goiter
- ☐ thyroid problem
- ☐ cholesterol / lipid problem

Blood (Hematopoietic / Lymphatic)
- ☐ anemia
- ☐ lymph node enlargement
- ☐ bleeding problem
- ☐ frequent infections

Psychiatric
- ☐ anxiety
- ☐ depression
- ☐ been seen by a psychiatrist

Lungs (Respiratory)
- ☐ shortness of breath
- ☐ cough
- ☐ sputum
- ☐ bronchitis
- ☐ asthma
- ☐ night sweats

Brain, Nerves, Spinal Cord (Neurologic)
- ☐ headaches
- ☐ dizziness
- ☐ blackouts
- ☐ numbness and tingling
- ☐ paralysis
- ☐ convulsions / seizures
- ☐ coordination trouble

Kidney, Bladder, Reproductive (Genitourinary)
- ☐ burning on urination
- ☐ frequency of urination
- ☐ difficulty starting urine
- ☐ wetting pants or bed
- ☐ bloody urine
- ☐ sexual difficulties

Heart & Blood Vessels (Cardiovascular)
- ☐ chest pain
- ☐ heart attack
- ☐ palpitations (irregular heart beat)
- ☐ heart failure
- ☐ edema (leg swelling)
- ☐ high blood pressure
- ☐ leg cramps with walking

Abdomen (Gastrointestinal)
- ☐ heartburn / indigestion
- ☐ difficulty swallowing
- ☐ stomach pains
- ☐ ulcers
- ☐ nausea / vomiting
- ☐ diarrhea
- ☐ hemorrhoids
- ☐ rectal bleeding
- ☐ black bowel movements
- ☐ change in bowel habits
- ☐ constipation
- ☐ frequent laxative use
- ☐ jaundice or hepatitis
- ☐ liver trouble
- ☐ gallbladder problems

Bone & Joint (Musculoskeletal)
- ☐ joint pain
- ☐ joint swelling or warmth
- ☐ joint stiffness
- ☐ muscle pain
- ☐ weakness
- ☐ back pain
- ☐ joint deformity

IN ORDER TO INSURE PROPER AND COMREHENSIVE CARE, YOU MUST FOLLOW-UP WITH YOUR PRIMARY CARE PHYSICIAN FOR ANY AND ALL MEDICAL PROBLEMS AND CONCERNS CHECKED HERE

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·Please check any of the following conditions you have or have had in the past.
·If you are unsure, please ask a staff member to assist you in filling out this form.
You may check more than one condition.

Medical Condition History Check this box if you have **no** medical problems ☐ no medical problems

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis - rheumatoid (verified with blood test)
- ☐ Arthritis - osteo, degenerative
- ☐ Blood Clot Year ☐☐☐☐
- ☐ Blood Transfusion Year ☐☐☐☐
- ☐ Bowel disease
- ☐ Cancer (specify)_____
- ☐ Cardiac Arrhythmia (Abnormal heart rate)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (Angina)
- ☐ Cerebrovascular Disease (Stroke)
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Diabetes
- ☐ Depression
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack Year ☐☐☐☐
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypercholesterolemia (Elevated Cholesterol)
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disorder - Cirrhosis
- ☐ Liver Disorder - Hepatitis
- ☐ Lung Disease
- ☐ Osteomyelitis
- ☐ Parkinson's
- ☐ Seizure Disorder
- ☐ Ulcer Disease
- ☐ Other (specify all other)_____

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? ○ Yes ○ No

Ear, Nose, Throat Surgeries

- ☐ Deviated Septum ☐☐☐☐
- ☐ Sinus Repair ☐☐☐☐
- ☐ Tonsillectomy ☐☐☐☐
- ☐ Tracheostomy ☐☐☐☐
- ☐ Vocal Cord Surgery ☐☐☐☐

Gastrointestinal Surgeries

- ☐ Appendectomy ☐☐☐☐
- ☐ Cholecystectomy (Gallbladder removed) ☐☐☐☐
- ☐ Colon Resection ☐☐☐☐
- ☐ Exploratory Laproscopy ☐☐☐☐
- ☐ Hernia ○ Femoral ○ Incisional ○ Inguinal ○ Umbilical ☐☐☐☐
- ☐ Liver Resection ☐☐☐☐
- ☐ Small Bowel Obstruction Repair ☐☐☐☐
- ☐ Splenectomy ☐☐☐☐

Gynecologic Surgeries

- ☐ Hysterectomy ☐☐☐☐
- ☐ Oophorectomy ☐☐☐☐
- ☐ Ruptured ectopic ☐☐☐☐
- ☐ Laprascopy ☐☐☐☐
- ☐ C-Section ☐☐☐☐

Urologic Surgeries

- ☐ Bladder Suspension ☐☐☐☐
- ☐ Bladder Removed ☐☐☐☐
- ☐ Lithotripsy (Stone Machine) ☐☐☐☐
- ☐ Prostatectomy (Prostate Removed) ☐☐☐☐
- ☐ Vasectomy ☐☐☐☐

General Surgeries

- ☐ Breast Biopsy ○ Right ○ Left ○ Bilateral ☐☐☐☐
- ☐ Mastectomy ○ Right ○ Left ○ Bilateral ☐☐☐☐
- ☐ Thyroid Surgery ☐☐☐☐
- ☐ Whipple ☐☐☐☐

Heart (Cardiac) Surgeries

- ☐ CABG # arteries ○ 1 ○ 2 ○ 3 ○ 4 ○ 4+ ☐☐☐☐
- ☐ Valve ○ Aortic ○ Mitral ○ Tricuspid ☐☐☐☐
- ☐ Angioplasty ☐☐☐☐
- ☐ Defibrillator ☐☐☐☐
- ☐ Pace Maker ☐☐☐☐

Vascular Surgeries

- ☐ Bypass Graft - Legs ☐☐☐☐
- ☐ Vascular Access ☐☐☐☐
- ☐ AAA ☐☐☐☐
- ☐ Thoracic Aneurysm ☐☐☐☐

Thoracic Surgeries

- ☐ Chest Tube ☐☐☐☐
- ☐ Pulmonary ☐☐☐☐
- ☐ Pectus ☐☐☐☐

Neurosurgeries

- ☐ Brain Tumor ○ Malignant ○ Benign ☐☐☐☐
- ☐ Brain Aneurysm ☐☐☐☐
- ☐ Chiari Decompression ☐☐☐☐
- ☐ Spinal Cord Tumor ○ Malignant ○ Benign ☐☐☐☐
- ☐ Epidural Injection ☐☐☐☐
- ☐ Abcess ☐☐☐☐
- ☐ Stent ☐☐☐☐

Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year | Previous Surgery Year (if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

- ☐ Fracture Repair - Finger ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Hand ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Wrist ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Arm ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Elbow ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Shoulder ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Hip/Pelvis ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Femur ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Knee ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Lower Leg ○ Right ○ Left ○ Bilateral
- ☐ Fracture Repair - Ankle/Foot ○ Right ○ Left ○ Bilateral

Ankle/Foot Surgeries

- ☐ Ankle Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Ankle Fusion ○ Right ○ Left ○ Bilateral
- ☐ Tendon Surgery ○ Right ○ Left ○ Bilateral
- ☐ Toe Surgery specify _____ ○ Right ○ Left ○ Bilateral

Elbow, Wrist, Hand Surgeries

- ☐ Biceps Repair ○ Right ○ Left ○ Bilateral
- ☐ Carpal Tunnel Surgery ○ Right ○ Left ○ Bilateral
- ☐ Elbow Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Elbow Ligament Reconstruction ○ Right ○ Left ○ Bilateral
- ☐ Elbow Replacement ○ Right ○ Left ○ Bilateral
- ☐ Hand Tendon Repair ○ Right ○ Left ○ Bilateral
- ☐ Nail Bed Surgery ○ Right ○ Left ○ Bilateral
- ☐ Tennis Elbow Surgery ○ Right ○ Left ○ Bilateral
- ☐ Trigger Finger Surgery ○ Right ○ Left ○ Bilateral
- ☐ Wrist Ligament Reconstruction ○ Right ○ Left ○ Bilateral

Knee Surgeries

- ☐ Knee Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Cartilage surgery/meniscus surgery ○ Right ○ Left ○ Bilateral
- ☐ Knee replacement ○ Right ○ Left ○ Bilateral
- ☐ Ligament reconstruction - ACL ○ Right ○ Left ○ Bilateral
- ☐ Ligament reconstruction - other ○ Right ○ Left ○ Bilateral

Hip Surgeries

- ☐ Hip replacement ○ Right ○ Left ○ Bilateral
- ☐ AVN Surgery ○ Core Decompression ○ Fibular Graft ○ Right ○ Left ○ Bilateral

Shoulder Surgeries

- ☐ Shoulder Arthroscopy ○ Right ○ Left ○ Bilateral
- ☐ Rotator cuff surgery ○ Right ○ Left ○ Bilateral
- ☐ Shoulder replacement ○ Right ○ Left ○ Bilateral
- ☐ Shoulder stabilization ○ Right ○ Left ○ Bilateral

Spine Surgeries

- ☐ Laminectomy ☐ Cervical ☐ Lumbar ☐ Thoracic
- ☐ Anterior Fusion ☐ Cervical ☐ Lumbar ☐ Thoracic
- ☐ Posterior Fusion ☐ Cervical ☐ Lumbar ☐ Thoracic
- ☐ Posterior Discectomy ☐ Cervical ☐ Lumbar ☐ Thoracic

Other (List all other surgeries) _____

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Drug Allergy and Medication Information

Have you ever had problems with anesthesia? ○ Yes ○ No *If yes, describe*_____

Are you allergic to latex? ○ Yes ○ No

Are you allergic to any medications? ○ Yes ○ No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other_____

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other_____

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other_____

Please list additional drug allergies here: _____

_____

Please check any anti-inflammatory medication listed below which you have taken in the past. Please include all prescription, non-prescription and samples

☐ Advil
☐ Arthrotec
☐ Bextra
☐ Celebrex
☐ Daypro
☐ Ibuprofen
☐ Indocin
☐ Lodine
☐ Naprelan
☐ Naproxen
☐ Oruval/Orudis
☐ Tylenol
☐ Ultram
☐ Vioxx
☐ Other (specify)_____

Please check any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

☐ nausea ☐ diarrhea ☐ gastric ulcers ☐ upset stomach ☐ vomiting ☐ other_____

Please check any of the following medications you take on a regular basis.

☐ Aspirin ☐ Axid ☐ Coumadin ☐ Cytotec ☐ Heparin ☐ Maalox ☐ Mylanta ☐ Pepcid ☐ Prevacid ☐ Prilosec ☐ Tagamet ☐ Zantac

Please list the medications you are currently taking - Please include prescription and non-prescription medication

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family Medical History

Please check all diseases for which you have a family history:

☐ Cancer - Breast
☐ Cancer - Prostate
☐ Cancer - Other
☐ Diabetes
☐ Heart Disease
☐ Stroke
☐ Rheumatoid Arthritis
☐ Arthritis - osteo, degenerative

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father ○ alive ○ deceased Age (current age or age deceased) ___

Health history ☐ cancer ☐ diabetes ☐ heart disease ☐ rheumatoid arthritis ☐ stroke ☐ osteoarthritis

Cause of death (if deceased)

Mother ○ alive ○ deceased Age (current age or age deceased) ___

Health history ☐ cancer ☐ diabetes ☐ heart disease ☐ rheumatoid arthritis ☐ stroke ☐ osteoarthritis

Cause of death (if deceased)

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Social History

Current Employment (Check only ONE answer)

○ full time ○ paid leave
○ part time ○ unpaid leave
○ retired ○ disabled by back/neck
○ student ○ disabled by today's problem
○ unemployed ○ disabled NOT by today's problem

Level of Education (Check only ONE answer)

○ grade school
○ high school/equivalent
○ some college
○ college degree
○ graduate degree

Job Title

Alcohol

○ I drink alcohol
○ I do not drink alcohol, but I used to drink alcohol
○ I never drank alcohol

If you drink alcohol, how frequently?

○ rarely (less than 1 drink a month)
○ occasionally (1-4 drinks per month)
○ socially (1-2 drinks per week)
○ frequently (3-5 drinks per week)
○ daily (at least one drink a day)

Tobacco

○ I use tobacco
○ I do not use tobacco, but I used to use tobacco
○ I have never used tobacco

If you use or used to use tobacco, cigarette packs per day

☐ 1/2 ☐ 2 and 1/2
☐ 1 ☐ 3
☐ 1 and 1/2 ☐ 3 and 1/2
☐ 2 ☐ 4

Years of tobacco use

Do you exercise regularly?

○ Yes ○ No

If you exercise, how often?

○ daily ○ 3 times per week ○ weekly ○ at least once every other week

Symptoms and Pain Survey

Duration of current symptoms:

○ no current symptoms ○ 3-6months
○ <1 week ○ 6months-1year
○ 1-3 weeks ○ 1-3 years
○ 3-6 weeks ○ 3-5 years
○ 6 weeks-3months ○ >5 years

Compared to 3 months ago, how would you rate your symtoms now?

○ much worse ○ a little worse ○ same ○ a little better ○ much better

Compared to 3 months ago, how worried are you about your condition now?

○ much less worried ○ less worried ○ no change ○ more worried ○ much more worried

Are you having pain today? ○ yes ○ no Is your pain today - ○ occasional ○ continuous/constant

On a scale of 0-10 (with 10 being the worst pain imaginable), how would you score your pain today?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Check the words that best describe the character of the pain you are having today.

☐ aching ☐ sharp ☐ penetrating
☐ throbbing ☐ tender ☐ nagging
☐ shooting ☐ burning ☐ numb
☐ stabbing ☐ exhausting ☐ miserable
☐ gnawing ☐ tiring ☐ unbearable

Does the pain awaken you from sleep?

○ never ○ occasionally ○ frequently

Does the pain keep you from sleeping?

○ never ○ occasionally ○ frequently

What time of day is your pain worst (CHECK ONLY ONE)?

○ morning ○ afternoon ○ evening ○ nighttime ○ all the time

What makes your pain better?

☐ rest ☐ lying down
☐ medication ☐ walking
☐ ice ☐ standing
☐ heat ☐ nothing in particular
☐ sitting ☐ other (specify)_____

What makes your pain worse?

☐ sitting ☐ activity in general
☐ standing ☐ stooping/bending
☐ lying down ☐ nothing in particular
☐ walking ☐ other (specify)_____
☐ exercising

If you had to spend the rest of your life with your condition the way it is now, how would you feel about it?

○ Delighted ○ Pleased ○ Mostly satisfied ○ Mixed ○ Mostly dissatisfied ○ Unhappy ○ Terrible

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SF-12 - Check ONLY ONE answer for each question

Hand Dominance: ○ **Right** ○ **Left** ○ **Use both equally**

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

○ 1 Excellent ○ 2 Very good ○ 3 Good ○ 4 Fair ○ 5 Poor

(#2 and #3) The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○ 1	○ 2	○ 3
3. Climbing several flights of stairs	○ 1	○ 2	○ 3

(#4 and #5) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
4. Accomplished less than you would like	○ 1	○ 2
5. Were limited in the kind of work or other activities	○ 1	○ 2

(#6 and #7) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
6. Accomplished less than you would like	○ 1	○ 2
7. Didn't do work or perform other activities as carefully as usual	○ 1	○ 2

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

○ 1 Not at all ○ 2 A little bit ○ 3 Moderately ○ 4 Quite a bit ○ 5 Extremely

(#9, #10 and #11) These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks

	All of the time	Most of the time	A good bit of time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
10. Did you have a lot of energy?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
11. Have you felt downhearted and blue?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
○ 1	○ 2	○ 3	○ 4	○ 5

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW