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:** ______________________