

Medical Information

Chart: _____

Form must be filled out before you see the physician. The information on the form provides basic information about your orthopedic problem and general health condition. This information is very important and can influence your orthopedic diagnosis and treatment.

Today's date: _____ Acct. #: _____ Imaging: _____

Name _____ Sex: _____ Date of birth: _____ Age: _____

Referring Doctor: _____

Height: _____ Weight: _____ Occupation: _____ Dominant hand: R L

What type of orthopedic problems are you being seen for? _____

Did your symptoms result from an accident? Yes _____ No _____ If yes, list dates and nature of accident: _____

If no, when did your problem first occur: _____

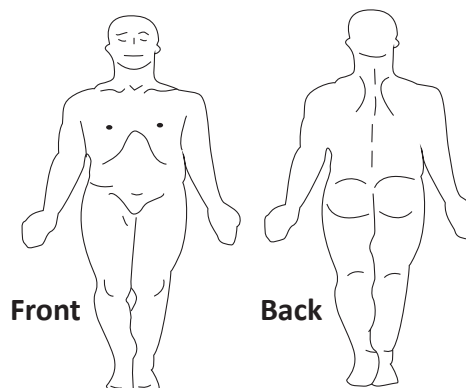
Have you seen a doctor for this problem? Yes _____ No _____

Please rate your pain area on the diagram.

Mark 1 for most painful

Mark 2 for next most painful

Mark 3 for next most painful



How would you describe your symptoms (check all that apply)

- Dull ache Stiffness 'Giving out' "Sleepy" Cold
- Sharp ache Popping Hot Weak Stabbing Tingling
- Tingling Numb Cracking Cramping Chills

Check the severity of your symptoms:

- Mild no compromise of activities Slight, some compromise of activities
- Moderate, marked compromise of activities Severe—unable to perform activities

Has this been improving? Improving Getting worse Remaining unchanged

How frequent are the symptoms in this area?

- Occasional—less than half the day Intermittent—about half the day
- Frequent—more than half the day Constant—all day and every day

What relieves the symptoms? _____

What makes the symptoms worse? _____

Have you had similar problems before? _____

Medical Information (cont.)



Name: _____ Date: _____

Which medical tests or treatments have you received for this problem?

- X-ray CT scan MRI Bone scan CT scan Blood tests Nerve tests (EMG)
 Myelogram Nerve injection (nerve root block) Joint injection Discogram (X-ray of discs in back)
 Other _____

List **ALL** surgeries you have had and the approximate date. (Example: hip replacement, 1999)

List **ALL** allergies and any reactions: _____

List **ALL** current medications you are taking. Include dosage AND time you take them.

Medicine (or herb)	Dosage	Frequency
(Example: Motrin)	800mg	One pill at 8:00 am and one pill at 4:00 pm

What active medical conditions do you have (check all that apply)

- Diabetes Rheumatoid arthritis COPD Sleep apnea
 AFIB Reflux Hypertension Anemia Other _____

List any serious past medical conditions you may have had _____

List any substance use:	Currently use	Previously used	How much	How long	Stopped
Tobacco	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
Caffeine (coffee, tea, soda)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
Beer, wine, liquor	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____
Recreation / street drugs	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____	_____

Family medical history:

Relative	Currently age	(or age at death)	Current medical conditions (or cause of death)
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers/Sister	_____	_____	_____
Children	_____	_____	_____

List hobbies: _____

List any exercise: _____

Check any of these **NEW** problems that may apply to you:

- Weakness/arms Weakness/legs Difficulty w/ balance Fevers Chills Sweats Loss of appetite
 Unexpected wt. loss (more than 10 lbs) History of cancer Bladder problems History of steroid use
 Constipation Bowel problems Pain wakes me up Fevers Other: _____

Review of symptoms:**General:** weight change other: _____**Skin:** rashes lumps sores change in color/size of mole other: _____**Head:** headaches head injury other _____**Eyes:** sudden loss of vision double vision cataracts glaucoma eye pain eye redness other: _____**Ears:** sudden loss of hearing ringing vertigo infection drainage**Nose and sinus:** nosebleeds sinus other _____**Mouth and throat:** dentures decayed teeth bleeding gums sores in mouth hoarseness difficulty swallowing other _____**Neck:** lumps in neck swollen glands goiter pain or stiff neck other**Breasts:** lumps nipple discharge dimpled skin other _____**Respiratory:** recurrent cough excessive sputum wheezing asthma emphysema pneumonia tuberculosis positive skin test for TB shortness of breath sleep apnea other _____**Cardiac:** high or low blood pressure rheumatic fever heart attack chest pain at rest or on exertion irregular heart rate swelling of both legs or ankles sleep on two or more pillows high cholesterol other _____**Blood vessels in legs:** leg cramps when walking varicose veins cold feet sores on feet or ankles blood clots in legs other**Gastrointestinal:** heartburn recurrent nausea or vomiting recurrent constipation or diarrhea rectal bleeding black stool loss of bowel control ulcer hernias abdominal pain jaundice liver or gall bladder problems hepatitis colon polyp/tumor other**Urinary:** frequent urination burning on urination recurrent bladder or kidney infections loss of bladdercontrol kidney stones decreased force of urinary stream blood in urine other _____**Male genital:** drainage from or sores on penis pain or lump in testicles prostatitis scrotal swelling difficulty in sexual functioning history of sexually transmitted disease other _____**Female genital:** date of last menstruation _____ age at menopause complications of pregnancy drainage from vagina sores or lumps in and around vagina abnormalbleeding difficulty in sexual function history of sexually transmitted diseases other _____**Nerve problems:** black-outs seizure or convulsions paralysis frequent or constant numbness or tingling in a body part abnormal memory loss tremors history of polio or muscular sclerosis or stroke Slurred speech other _____**Blood problems:** anemia easy bruising or bleeding splenectomy leukemia other**Other glands:** over/under active thyroid diabetes excessive urination sweating or thirst enlarged**Lymph nodes:** other _____**Emotional problems:** excessive nervousness worry anxiety depression insomnia**Other:** _____