## Health History - Orthopedics

**Name:** _____ **DOB:** _____
**Preferred Name (Nickname):** **Pharmacy**
**Name:** _____ **Pharmacy Address:** _____
**PCP/Referring Provider Name:** _____
**List of all doctors you see (Care Team):** _____

**Reason for today's visit:** _____
**When did your symptoms begin?** _____
**What triggers your symptoms?** _____
**What makes your symptoms better?** _____
**Grade your pain 0-10 (0= no pain and 10=worst pain):** 10 = worst pain
**What treatment have you had for your symptoms?** _____
**Affected Side:** ☐ Left ☐ Right ☐ Both
**Body Area:** ☐ Knee ☐ Shoulder ☐ Hip ☐ Ankle ☐ Elbow ☐ Foot ☐ Hand ☐ Wrist ☐ Spine
☐ Other: _____

Is your problem getting: ☐ Worse ☐ Better ☐ Staying the same

**What studies have you done?** ☐ CT ☐ MRI ☐ Bone Scan ☐ Other_____

**Have you had injections?** ☐ Yes ☐ No

**If so, where:** _____
**How much did it help?** _____
**For how long?** _____
**Any additional complaints?** _____

Was this a result of an injury? ☐ Yes ☐ No

If yes, please complete the following questions:

What type of injury? ☐ Auto ☐ Worker's Compensation ☐ Other

Date of Injury: _____

Describe how it happened? _____

If injured, is litigation ongoing? ☐ Yes ☐ No

Are you: ☐ Off Work ☐ Modified Duty ☐ Full Duty

**ALLERGIES** List all allergies to medications or foods and your reaction:

| ALLERGY | REACTION |
|---|---|
| | |
| | |
| | |

**MEDICATIONS** Please list all medicines you are currently taking (include over the counter such as vitamins):

| NAME OF MEDICATION | DOSAGE | HOW OFTEN PER DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**FAMILY HISTORY** Please list any relative with the following medical problems and their relationship to you:

| | Relation | | Relation |
|---|---|---|---|
| ☐ Aneurysm | | ☐ Heart Disease | |
| ☐ Arthritis | | ☐ History of Emphysema | |
| ☐ Back Problem | | ☐ Multiple Sclerosis | |
| ☐ Blood Clotting Disorder | | ☐ Osteoporosis | |
| ☐ Deep Venous Thrombosis | | ☐ Parkinson's Disease | |
| ☐ Diabetes Mellitus | | ☐ Rheumatoid Arthritis | |
| ☐ Family History of Cancer | | ☐ Substance Abuse | |
| ☐ Gout | | | |

**SOCIAL HISTORY**

| | |
|---|---|
| Tobacco Use | Do you currently use tobacco? ☐ Yes ☐ No<br>Did you use tobacco in your past? ☐ Yes ☐ No<br>How Long? _____ Year Quit: _____<br>☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/day |
| Live alone or with others? | ☐ Alone ☐ With others |
| Employment | Occupation: Employer: |
| Single or Multi-level home/work | ☐ Single Level Home ☐ Multi-Level Home<br>☐ Single Level Work ☐ Multi-Level Work |
| Able to care for self ? | ☐ Yes ☐ No |
| Hand dominance | ☐ Right ☐ Left ☐ Bilateral |
| Sports Activities | |
| General Stress Level | ☐ Low ☐ Medium ☐ High |
| Exercise Level | ☐ None ☐ Occasional ☐ Moderate ☐ Heavy |
| Diet | ☐ Regular ☐ Vegetarian ☐ Gluten Free ☐ Carbohydrate ☐ Cardiac ☐ Diabetic |
| Caffeine Intake | ☐ None ☐ Occasional ☐ Moderate ☐ Heavy<br># of cups/cans per day _____ |
| Alcohol Intake | ☐ None ☐ Occasional ☐ Moderate ☐ Heavy<br>How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? ____ |
| Is blood transfusion acceptable in an emergency? | ☐ Yes ☐ No |
| Advance directive? | ☐ Yes ☐ No |

**PAST SURGICAL HISTORY** Have you ever had the following:

| | Year | | Year | | Year |
|---|---|---|---|---|---|
| ☐ Achilles Tendon Repair | | ☐ Device Implant | | ☐ Knee Surgery | |
| ☐ Amputation | | ☐ Elbow Surgery | | ☐ Lumbar Spine Surgery | |
| ☐ Ankle/Foot Surgery | | ☐ Fem Fem Bypass | | ☐ Open Reduction Internal Fixation | |
| ☐ Arthroscopic Surgery | | ☐ Fem Pop Bypass | | ☐ Orthopedic Surgery | |
| ☐ Arthroscopic/Knee | | ☐ Fem Tib Bypass | | ☐ Popliteal Artery Stent | |
| ☐ Axillo-Fem Bypass | | ☐ Fracture Surgery | | ☐ Popliteal Balloon Angioplasty | |
| ☐ Back Surgery | | ☐ Hand Surgery | | ☐ Popliteal Tibial Bypass | |
| ☐ Bone Marrow | | ☐ Hip Replacement | | ☐ Shoulder Surgery | |
| ☐ Cancer Surgery | | ☐ Hip Surgery | | ☐ Spine Surgery | |
| ☐ Carpal Tunnel Syndrome | | ☐ Joint Replacement | | ☐ Other: | |
| ☐ Cervical Spine Surgery | | ☐ Knee Replacement | | | |

*Any other Medical/Surgical history/conditions, please inform the nurse.*

**PAST MEDICAL HISTORY** Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Allergies | ☐ | ☐ | Headaches/Migraine | ☐ | ☐ |
| Anemia | ☐ | ☐ | Hearing Loss | ☐ | ☐ |
| Arthritis Rheumatoid | ☐ | ☐ | Heart Disease | ☐ | ☐ |
| Arthritis Osteoarthritis | ☐ | ☐ | Heart Rhythm Disorder | ☐ | ☐ |
| Asthma | ☐ | ☐ | Hyperlipidemia | ☐ | ☐ |
| Autoimmune Disease | ☐ | ☐ | Kidney Disease/Stones | ☐ | ☐ |
| Back/Neck Pain | ☐ | ☐ | Liver Disease/Hepatitis | ☐ | ☐ |
| Bleeding Disorder/DVT | ☐ | ☐ | Lung Disease | ☐ | ☐ |
| Blood Disorder | ☐ | ☐ | Mental Illness | ☐ | ☐ |
| Bowel Disease | ☐ | ☐ | Movement Disorder | ☐ | ☐ |
| Coronary Artery Disease | ☐ | ☐ | Nerve Disease | ☐ | ☐ |
| Congestive Heart Failure | ☐ | ☐ | Osteopenia/Osteoporosis | ☐ | ☐ |
| COPD | ☐ | ☐ | Overweight/Obesity | ☐ | ☐ |
| Dementia | ☐ | ☐ | Pneumonia | ☐ | ☐ |
| Depression | ☐ | ☐ | Prostate Disorder | ☐ | ☐ |
| Developmental Disorder | ☐ | ☐ | Spine Disease | ☐ | ☐ |
| Diabetes Type 1 | ☐ | ☐ | Stroke/TIA | ☐ | ☐ |
| Diabetes Type 2 | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Diabetic Complications | ☐ | ☐ | Tuberculosis or + TB test | ☐ | ☐ |
| Endocrine Disease | ☐ | ☐ | Urinary Problem | ☐ | ☐ |
| Eye Problems | ☐ | ☐ | Viral Disease | ☐ | ☐ |
| Fibromyalgia/Pain Disorder | ☐ | ☐ | Other: | ☐ | ☐ |
| Gastritis/Ulcer | ☐ | ☐ | | | |
| GERD/Acid Reflux | ☐ | ☐ | | | |

## Review of Systems

**Check all that apply:**

**Constitutional**

- ☐ Yes ☐ No Recent Weight Change
- ☐ Yes ☐ No Decreased Appetite
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Sweats
- ☐ Yes ☐ No Fatigue

**Head**

- ☐ Yes ☐ No Headaches

**Eyes**

- ☐ Yes ☐ No Vision Changes
- ☐ Yes ☐ No Eye Disease/Injury

**ENMT**

- ☐ Yes ☐ No Difficulty Hearing/Ringing
- ☐ Yes ☐ No Sinus Pain
- ☐ Yes ☐ No Nosebleeds
- ☐ Yes ☐ No Nasal Discharge
- ☐ Yes ☐ No Teeth/Gum Problems

**Cardiovascular**

- ☐ Yes ☐ No Heart Trouble
- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Palpitations
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Swelling of Feet/ Ankles/Hands
- ☐ Yes ☐ No High Blood Pressure

**Breast/Chest**

- ☐ Yes ☐ No Breast Pain
- ☐ Yes ☐ No Breast Mass/Lump
- ☐ Yes ☐ No Nipple Discharge

**Respiratory**

- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Difficulty Breathing

**Gastrointestinal**

- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No Appetite Changes
- ☐ Yes ☐ No Change in Bowel Movement
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Rectal Bleeding
- ☐ Yes ☐ No Stomach Ulcer

**Genitourinary**

- ☐ Yes ☐ No Kidney Disease

**Musculoskeletal**

- ☐ Yes ☐ No Muscle Pain
- ☐ Yes ☐ No Joint Pain

**Integumentary**

- ☐ Yes ☐ No Rash/Mole Change
- ☐ Yes ☐ No Itching/Rash
- ☐ Yes ☐ No Change in Hair/Nails
- ☐ Yes ☐ No Change in Skin Color
- ☐ Yes ☐ No Varicose Veins

**Neurologic**

- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Dizziness or Lightheadedness
- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Memory Loss
- ☐ Yes ☐ No Loss of Coordination

**Heme/Immunology**

- ☐ Yes ☐ No Slow to Heal After Cuts
- ☐ Yes ☐ No Bleeding/Bruising Tendency
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Blood Clots
- ☐ Yes ☐ No Blood Transfusion
- ☐ Yes ☐ No Enlarged Glands

**Allergic/Immunologic**

- ☐ Yes ☐ No HIV

**Skin Reaction or Other Adverse Reaction to:**

- ☐ Yes ☐ No Penicillin/Antibiotics
- ☐ Yes ☐ No Morphine/Demerol Other Narcotics

**Endocrine**

- ☐ Yes ☐ No Glandular/Hormone Problem
- ☐ Yes ☐ No Thyroid Disease
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Excessive Urination

**Psychiatric**

- ☐ Yes ☐ No Problems with Sleep
- ☐ Yes ☐ No Memory Loss/Confusion