ORA ORTHOPEDICS

Patient Name: _____ **Provider:** _____

Date of Birth: _____ **Chart #** _____ **Date:** _____

MEDICAL HISTORY FORM

Age: _____ **Sex**: ☐ F ☐ M **Dominant Hand**: ☐ R ☐ L **Height:** _____ **Weight**: _____ **(ORA Only BMI _____)**

What problem are you being seen for today? ☐ R ☐ L _____

Were you seen in the E.R. for this problem? ☐ Y ☐ N **Which E.R.?** _____ Date _____

Referred Here By: ☐ Self ☐ Family ☐ Friend ☐ Primary Care ☐ ER / Urgent Care ☐ Other Healthcare Provider

Name of person making referral: _____ **Did they evaluate this problem?** ☐ Y ☐ N

Your primary care physician: _____ **Internist:** _____ **Cardiologist** _____

Neurologist: _____ **Pulmonologist (Lung):** _____ **Other Specialist:** _____

PROBLEM OR INJURY

When did your problem begin (date): _____ **Where did the injury occur?** _____

Was there an injury? ☐ Y ☐ N **Did this occur at work?** ☐ Y ☐ N **Related to a Motor Vehicle Accident?** ☐ Y ☐ N

What tests have you had for this problem? ☐ X-Rays _____ *Where & When* ☐ MRI _____ *Where & When* ☐ CT Scan _____ *Where & When*

☐ Bone Scan _____ *Where & When* ☐ Nerve Test (EMG/NCV) _____ *Where & When* ☐ Other_____ *Where & When*

Prior treatments for this problem? ☐ Ice ☐ Heat ☐ NSAIDS/Ibuprofen ☐ Physical Therapy ☐ Injections ☐ Pain Pills ☐ Compression or Bracing ☐ Chiropractic ☐ Surgery ☐ Other Medications

I experience: ☐ Pain ☐ Numbness ☐ Weakness ☐ Locking / Catching ☐ Instability ☐ Swelling ☐ Stiffness

Scale of 0 – 10 how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 **Pain wake you from sleep?** ☐ Y ☐ N

No Pain > > > > > > > > > > > > > > > Worst Pain

Has your problem kept you from: ☐ Working ☐ Recreational Activities ☐ Activities of Daily Living (Cleaning & Dressing Yourself)

What makes your symptoms <u>worse</u>? ☐ Walking ☐ Stairs ☐ Exercising ☐ Twisting ☐ Kneeling ☐ Direct Pressure ☐ Standing ☐ Sitting ☐ Lying Flat ☐ Bending ☐ Lifting ☐ Coughing / Sneezing

If there was a specific injury, please describe what happened:

_____

_____

_____

_____

_____

_____

_____

_____

Continue on Other Side >>>>>

Patient Name: _____ **Provider:** _____

Date of Birth: _____ **Chart #** _____ **Date:** _____

PAST MEDICAL HISTORY

Do you have a history of any of the following: (Please ☑ check all that apply)

Heart
- ☐ Heart Failure / CHF
- ☐ Heart Attack
  When _____ (Year)
- ☐ Pacemaker
- ☐ A-Fib
- ☐ Defibrillator

Smoking / Alcohol
- ☐ Smoke_____ Packs/Day
- ☐ Vape / Chew Tobacco
- ☐ Quit Smoking or Tobacco
  When _____(Date)
- ☐ Alcohol_____Drinks/Week
- ☐ Marijuana
- ☐ Recreational Drugs

Bones/Joints
- ☐ Broken
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Psoriatic Arthritis
- ☐ Gout
- ☐ Lyme Disease
- ☐ Ehlers Danlos

Anesthesia Reaction
- ☐ Severe Reaction
  Explain_____
- ☐ Difficult Intubation
- ☐ Malignant Hyperthermia
- ☐ Significant Nausea
- ☐ Severe Motion Sickness

Circulation
- ☐ Blood Clots
- ☐ Pulmonary Embolism
- ☐ On Blood Thinner
- ☐ High Blood Pressure
- ☐ On Blood Press Meds
- ☐ Stroke _____ (Year)
- ☐ Elevated Cholesterol

Lung
- ☐ Asthma
- ☐ COPD
- ☐ On Home Oxygen
- ☐ Sleep Apnea
- ☐ Use CPAP

☐ **Cancer**
_____(Type)

Kidney
- ☐ Infection _____(Year)
- ☐ Stones
- ☐ Dialysis
- ☐ Kidney Disease

Neuro
- ☐ Neuropathy
- ☐ Seizures
  When _____(Year)

Digestive
- ☐ Reflux
- ☐ Ulcers

Psych
- ☐ Drug / Alcohol Abuse
- ☐ Depression
- ☐ Anxiety

Glands
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ On Insulin
- ☐ Thyroid Disease
- ☐ Last A1C _____

Current/Past Infection
- ☐ Pneumonia
- ☐ Hepatitis ☐B ☐C
- ☐ HIV / AIDS
- ☐ MRSA
- ☐ VRE
- ☐ COVID-19
  When _____
- ☐ Current Infection

Check <u>past surgeries</u> that you have had: ☐ **NONE**

☐ Heart Surgery _____(Year) ☐ Bypass ☐ Catheterization ☐ Stents #_____ and _____(Year) ☐ Valve Replaced

Other Surgery _____

☐ Knee Arthroscopy (R / L) ☐ Shoulder Arthroscopy / Rotator Cuff (R / L) ☐ Knee Replacement (R / L) ☐ Shoulder Replacement (R / L)

☐ Hip Replacement (R / L) ☐ ACL Surgery (R / L) ☐ Spine Surgery _____ Other Orthopedic Surgery _____

<u>Current medications, the dose and frequency</u> (list all prescription and over the counter medications / supplements):

☐ **NONE** ☐ **Please see list on separate sheet (please date the sheet and write your name on the sheet)**

_____

_____

Are you <u>allergic to any medications</u>? ☐ Y ☐ N If yes, please list below and list the reaction (hives, difficulty breathing, rash, swelling)

Medications Allergic to and Reaction:_____

☐ **Other Allergies:** ☐ Latex ☐ Food _____(Type) ☐ Other _____

FAMILY HISTORY

☐ Adopted and family medical history is not known ☐ No significant medical history of any direct relatives

Check if you have Family History (Mother, Father, Grandparents, Siblings or Children) of these problems:

☐ Blood Clots ☐ Bleeding Disorders ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Kidney Disease ☐ Rheumatoid Arthritis

☐ Lung Disease ☐ Diabetes ☐ Seizures ☐ Liver Disease ☐ Malignant Hyperthermia ☐ Lupus ☐ Cancer _____(Type)

SOCIAL HISTORY

Are you currently working? ☐ Y ☐ N **Type of job:** _____ ☐ Disabled ☐ Retired

Student at _____ **What Grade** _____ **Participating in What Sports** _____

Are you pregnant? ☐ Y ☐ N ☐ Unknown **Started Menstrual Period** (Females 8-15) ☐ Y ☐ N What Age _____

Patient Signature The information on this form is accurate to the best of my knowledge. **Date**

FOR OFFICE USE ONLY: (Initial and date when completed and with each update)

Review#1 by: Date Review #2 by: Date Form-#285