FAYETTEVILLE ORTHOPAEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

Patient Name: _____ Height: _____ Weight: _____

Race: ○ African American ○ Asian ○ Caucasian ○ Other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____ Location: _____ Ph#: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: **(select only ONE primary symptom and ONE affected area)**

○ Pain ○ Numbness/Tingling ○ Fracture/ Break ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○		
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back	○		
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back	○		
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back	○		
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks	○		
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone	○		
Thumb	○ Right	○ Left	Foot	○ Right	○ Left				
Index Finger	○ Right	○ Left	Big Toe	○ Right	○ Left				
Middle Finger	○ Right	○ Left	2nd Toe	○ Right	○ Left				
Ring Finger	○ Right	○ Left	3rd Toe	○ Right	○ Left				
Small Finger	○ Right	○ Left	4th Toe	○ Right	○ Left				
			5th Toe	○ Right	○ Left				

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

3. Have you been seen in an ER for this problem? ○ Yes ○ No

Treating ER: (Ex. CFV) _____ Date: (mm/dd/yyyy) _____

4. Rate the pain (10 being the most pain):

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

5. Do the symptoms wake you from sleep? ○ Yes ○ No

6. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

7. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

8. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

9. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

10. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan (DXA/DEXA)

Prior treatment for this problem:

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
HomeExerciseProgram	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____

Social History

Do you smoke tobacco? ○ Current, every day smoker ○ Current, some day smoker ○ Former smoker ○ Never
Type? _____ How many? _____ How Often? _____

Do you drink alcohol? ○ Yes ○ No How much? _____ How Often? _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled ○ Student
If no, what date did you last work? _____

Please list work restrictions, if any: _____

Occupation: _____ Employer: _____

Select all previous surgeries: ○ None

○ Aortic Bypass / Vascular Surgery	○ LAP Band / Gastric Bypass
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	○ Thyroidectomy
○ Hysterectomy	○ Tonsillectomy

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
TotalShoulderReplacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

				None	Comments
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	_____
2) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats	○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue	○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss	○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	_____
6) CV	○ Chest Pain	○ Palpitations		○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	_____
10) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness		
11) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○	_____

Family History- Have any direct relatives had any of the following disorders?

Father	○ Bleeding Problems	○ Diabetes	○ Heart Disease	○ Hypertension
○ None	○ Stroke	○ Epilepsy	○ Rheumatoid Arthritis	○ Muscular Dystrophy
	○ Osteoporosis	○ Cancer	Type or Other	_____
Mother	○ Bleeding Problems	○ Diabetes	○ Heart Disease	○ Hypertension
○ None	○ Stroke	○ Epilepsy	○ Rheumatoid Arthritis	○ Muscular Dystrophy
	○ Osteoporosis	○ Cancer	Type or Other	_____
Sibling	○ Bleeding Problems	○ Diabetes	○ Heart Disease	○ Hypertension
○ None	○ Stroke	○ Epilepsy	○ Rheumatoid Arthritis	○ Muscular Dystrophy
	○ Osteoporosis	○ Cancer	Type or Other	_____

Medical Questions- Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No Latex allergy? ○ Yes ○ No

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food	Reaction

Please list all current medications: ○ None

Medication	Dosage, Frequency, Route of Admin, Reason (e.g. 20 mg, 1x/day oral-asthma)

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ MRSA Infection/ Staph
○ Angina (Chest Pain)	○ Epilepsy	○ Osteoporosis
○ Arthritis Type: _____	○ Heart Attack	○ Pacemaker
○ Asthma	○ Hepatitis Type: _____	○ Phlebitis (Blood Clots)
○ Bone or Joint Infections	○ HIV / AIDS	○ Pulmonary Embolism
○ Cancer Type: _____	○ High Cholesterol	○ Reaction to Anesthesia
○ Chemotherapy / Radiation	○ High Blood Pressure	○ Seizures
○ COPD	○ Hyperthyroidism	○ Stomach Ulcers
○ Congestive Heart Failure	○ Hypothyroidism	○ Stroke / TIA
○ Diabetes _____	○ Kidney Disease	○ Tuberculosis
○ Gout _____	○ Kidney Stones	

Please list any other conditions or details of conditions marked above:

_____

_____

_____ _____

Signature Date