



Centers for
Orthopaedics
Experience in Motion

Medical History

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PLEASE BRING THIS COMPLETED FORM WITH YOU AT THE TIME OF YOUR EVALUATION

Please answer all questions. If you do not know the answer or do not understand the question, insert a question mark in the space. Please Do Not Leave Blank Spaces.

Name _____ Date of Visit _____

Your Height _____ Your Weight _____ DOB _____ Age _____

HEALTH CARE PROVIDER NAMES (Physician, Nurse Practitioner, or Physician Assistant)

1. _____ Approximate date of last visit _____

2. _____ Reason for last visit Annual Other _____

ALLERGIES None Known

Please list all medications and substances to which you are allergic and the type of reaction you have to the substance.

ALLERGY	EFFECT	ALLERGY	EFFECT
1.		3.	
2.		4.	

Do you have an allergy to: Latex? No Yes Tape or Adhesives? No Yes *If yes, please explain* _____

CURRENT MEDICATIONS

List all the medications you are now taking, including aspirin, pain medications, hormones, contraceptives, water pills, diet pills, vitamins, herbal medications, or sleeping pills.

MEDICATION	STRENGTH	FREQUENCY TAKEN	MEDICATION	STRENGTH	FREQUENCY TAKEN
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Have you ever used steroid medications (cortisone, prednisone, etc.)? Yes No

Reason for steroid treatment? _____ Date last taken _____

List all current medical problems (*for example: high blood pressure, angina, ulcers, diabetes, irritable bowel syndrome*).

PROBLEM	HOW LONG?	DOCTOR/PROVIDER
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PAST SURGICAL HISTORY

List all operations and their dates, most recent first. (*If you have had more than three surgeries, please continue on separate sheet.*)

TYPE OF SURGERY	DATE OF SURGERY	SURGEON	TYPE OF ANESTHESIA (General/Spinal/Local)
1.			
2.			
3.			
4.			

Have you had any problems with anesthesia? Yes No *If yes, please explain.* _____

PAST MEDICAL HISTORY - List all hospitalizations, excluding operations

PROBLEM	DATE	HOSPITAL/CITY	DOCTOR
1.			
2.			
3.			
4.			

Date of last EKG _____ Where? _____

Recent lab tests? _____ Where? _____

Date of last chest x-ray _____ Where? _____ Any abnormal findings? Yes No

PREVIOUS BONE DENSITY TESTING: Yes No WHEN? _____ WHERE? _____

Have you had a previous MRSA or staph infection? Yes.... No

If yes, was your last culture? Positive Negative

Do you currently reside in a skilled nursing facility? Yes.... No

Are you incarcerated? Yes No

Are you a dialysis patient? Yes No

Are you an IV drug user? Yes No

PERSONAL & FAMILY HISTORY

What type of work do you do? _____

Do you drink alcohol? No Yes If yes, what kind and how much? _____

Do you smoke? No Yes If yes, what, and how much? _____

If you used to smoke, how many years did you do so and when did you quit? N/A _____

Do you exercise regularly? _____ What type of physical activity do you perform regularly? _____

Do you have someone to assist you at home? Yes No _____

Number of stairs into your house/apartment and/or bedroom? _____

FAMILY HEALTH

Have any blood relatives ever had any of the following? If so, indicate their relationship to you. (e.g., Diabetes - maternal grandmother)

- | | | | | | |
|---------------|--|---------------------|--|--------------------------------|--|
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any unusual disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Malignant hyperthermia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unusual reaction to anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If your mother, father, or any of your brothers and/or sisters died, what was the cause of their death and their age at the time of death?

REVIEW OF SYSTEMS Please answer all questions by checking yes or no. If you do not know the answer or do not understand a question, please check the question mark box.

GENERAL

- Recent weight gain or loss Yes No ?
- Fatigue, currently Yes No ?
- Recent fever Yes No ?
- Recent change in appetite Yes No ?
- Recent change in sleep pattern Yes No ?
- Sleep apnea/snoring Yes No ?

MUSCULOSKELETAL

- Neck stiffness or loss of motion Yes No ?
- TMJ (jaw) problems Yes No ?
- Date of last dental exam _____

RESPIRATORY

ENDOCRINOLOGY

- Hormone problem/treatment Yes No ?
- Thyroid disease Yes No ?
- Diabetes Yes No ?

HEMATOLOGY

- Anemia/Low blood count Yes No ?
- Bleeding or bruising tendency Yes No ?
- Cancer Yes No ?
- X-ray therapy Yes No ?
- Phlebitis or blood clots (DVT) Yes No ?
- Frequent bloody nose/bleeding gums Yes No ?

SKIN

Sinus infections Yes No ?
 Wheezing Yes No ?
 Asthma Yes No ?
 Pneumonia Yes No ?
 Pleurisy Yes No ?
 Tuberculosis Yes No ?
 Chronic bronchitis Yes No ?
 Emphysema Yes No ?
 Coughing of blood Yes No ?

Coughing of phlegm Yes No ?
 Night sweats Yes No ?

CIRCULATORY/CARDIAC

Heart trouble Yes No ?
 Heart murmur Yes No ?
 Heart attack Yes No ?
 Chest pain/discomfort/heaviness Yes No ?
 High blood pressure Yes No ?
 Palpitations Yes No ?
 Rheumatic fever Yes No ?
 High cholesterol Yes No ?

Varicose veins Yes No ?
 Swelling of ankles Yes No ?
 Calf pain when walking? Yes No ?

DIGESTIVE

Special diet? Yes No ?
 Difficulty chewing/swallowing Yes No ?
 Ulcer Yes No ?
 Frequent Heartburn Yes No ?
 Hiatal or esophageal hernia Yes No ?
 Vomiting of blood Yes No ?
 Bloody or tarry stools Yes No ?
 Hepatitis or yellow jaundice Yes No ?

Liver trouble Yes No ?
 Gallbladder trouble or stones Yes No ?
 Persistent diarrhea/constipation Yes No ?
 Diverticulosis/diverticulitis Yes No ?
 Hernia (groin) Yes No ?

Irritable bowel syndrome/colitis Yes No ?
 Other digestive disease _____

Any recent rashes or lumps? Yes No ?
 Any skin infection currently? Yes No ?

URINARY

Bladder infection Yes No ?
 Kidney disease Yes No ?
 Abnormal urine test Yes No ?
 Kidney stones Yes No ?
 Prostate trouble Yes No ?

How many times do you wake up to urinate each night? _____

NEUROLOGICAL

Frequent or recurring headache Yes No ?
 Loss of consciousness Yes No ?
 Convulsions or seizures Yes No ?
 Head injury Yes No ?
 Stroke Yes No ?
 Nervous breakdown Yes No ?
 Psychiatric condition Yes No ?
 Depression/nervousness Yes No ?
 Weakness Yes No ?
 Sudden vision or speech changes Yes No ?
 Other neurologic disease _____

RHEUMATOLGICAL

Rheumatoid Arthritis Yes No ?
 Lupus Yes No ?
 Fibromyalgia Yes No ?

SPECIAL SENSES

Eye drops Yes No ?
 Glaucoma Yes No ?
 Cataracts Yes No ?
 Deafness Yes No ?
 Abnormal noises in the ear Yes No ?

OBSTETRIC & GYNECOLOGICAL

(Women only)
 Breast tumor or cyst? Yes No ?

Have you ever had toxemia? Yes No ?
 Are you currently pregnant? Yes No ?
 Date of last normal menstrual period _____

 Patient signature/date

 Physician/PA/NP signature/date

Below This Line for Office Use Only:

History and Physical

Problem

Surgery Date

Name: _____ Date of Birth _____ Account # _____

X-ray: _____
MRI: _____

ROS	WNL	Findings
General	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	_____
Circulatory	<input type="checkbox"/>	_____
Digestive	<input type="checkbox"/>	_____
Endocrine	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	_____
Hematology	<input type="checkbox"/>	_____
OB/GYN/GU	<input type="checkbox"/> <input type="checkbox"/> N/A	_____
Neurological	<input type="checkbox"/>	_____
Special Senses	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	_____

PHYSICAL EXAMINATION Pulse _____ Blood Pressure _____ / _____ Respiration _____ Ht. _____ Wt. _____ BMI _____

General _____

HEENT NCAT EOMI Oropharynx Benign _____

Respiratory CTA Bilat _____

Cardiac RRR Ø M/R/G 2+ UE / LE pulses bilat Ø carotid bruits bilat. _____

Abdomen S, NT NI BS Ø HSM or masses _____

Neuro A+O x 3 CN II-XII intact _____

Orthopaedic Exam Op site: intact skin Ø swelling distal sensation intact (affected extremity) _____

ASSESSMENT _____

PLAN _____ Date of Surgery ____/____/____

Informed consent obtained after discussion of the procedure, risks, expected course and follow-up protocol.

Pt. will stop following meds: ASA 1 week pre-op Other: _____

Physician Signature _____ Date _____ Physician Assistant/Nurse Practitioner Signature _____ Date _____