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Orthopedic History and Physical

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Answer all questions to the best of your ability to assist your doctor with your care.

PLEASE BE SURE TO BRING THIS FORM WITH YOU TO YOUR APPOINTMENT, DO NOT DROP IT OFF BEFOREHAND.

Name _____

Date: _____

SS# _____

Birth date: _____

Height: ___ FT ___ IN

Weight: ___ LB

Shoe size: _____

Age: _____

Dominant Hand: ___ Right ___ Left

Referring Doctor (name and address) _____

Internist or Family Doctor (name and address) _____

HISTORY OF PRESENT ILLNESS

1. **CHIEF COMPLAINT** (Why are you seeing the doctor today?) _____

2. How long have you had this problem? _____

3. What started the problem? _____

yes no when?

4. Has the problem become worse? _____

5. Is this problem the result of a car accident? _____

6. Is this problem the result of a work accident? _____

7. Have you missed any work because of this problem? _____

8. Have you missed any school because of this problem? _____

9. **Signs associated with your chief complaint:** *check all that apply*

___ **None Apply**

Sign	Location	Sign	Location
___ Swelling	_____	___ Drainage	_____
___ Redness	_____	___ Muscle atrophy	_____
___ Warmth	_____	___ Muscle spasm	_____
___ Edema	_____	___ Muscle twitching	_____
___ Skin changes	_____	___ Loss of movement	_____
___ Bruising	_____	___ Other	_____

10. Symptoms associated with your chief complaint: check all that apply ___ None Apply

___ Pain ___ Numbness or tingling

___ Weakness ___ Other _____

11. Is your chief complaint made worse by: check all that apply ___ None Apply

___ Sitting ___ Walking ___ Movement (what body part) _____

___ Standing ___ Going up stairs ___ Touch (what body part) _____

___ Laying down ___ Going down stairs ___ Other _____

12. Does anything make your chief complaint better? ___ Yes ___ No

If yes, please list: _____

13. Rate your pain severity using the following scale: My pain level is: (circle a number) ___ None Apply

1	2	3	4	5	6	7	8	9	10
None	Slight	Moderate		Severe		Extreme	Could not be worse		

14. Describe the quality of your pain? Check all that apply : ___ None Apply

___ Sharp ___ Stabbing ___ Shooting ___ Other _____

___ Dull ___ Throbbing ___ Continuous ___ Other _____

___ Burning ___ Aching ___ Intermittant ___ Other _____

15. Treatments for your chief complaint have included: (check all that apply) ___ None Apply

___ Physical therapy; exercise ___ Manipulation ___ Anti-inflammatory medication ___ Pain medication

___ Massage and ultrasound ___ Tens unit ___ Traction ___ Braces

___ other (list) _____

16. Medicines taken for your current problem: How much? How often?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Write on the back of this form if more medications

17. Previous doctors seen for this problem: ___ None

Doctor	Specialty	location (city)	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

18 Tests done to evaluate your problem: Check all that apply

None Apply

Test	Area Tested	Date	Test Location	Test	Area Tested	Date	Test Location
<input type="checkbox"/> Plain X-rays	_____	_____	_____	<input type="checkbox"/> Myelogram	_____	_____	_____
<input type="checkbox"/> Arthrogram	_____	_____	_____	<input type="checkbox"/> Bone Scan	_____	_____	_____
<input type="checkbox"/> MRI	_____	_____	_____	<input type="checkbox"/> EMG	_____	_____	_____
<input type="checkbox"/> CAT Scan	_____	_____	_____	<input type="checkbox"/> Other	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	<input type="checkbox"/> Other	_____	_____	_____

Review of Systems: Check all that apply

None Apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Tooth problems |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Chest pain with breath | <input type="checkbox"/> Change in urine function |
| <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Abnormal heart beat | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Very low energy | <input type="checkbox"/> Short of breath with walking | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Change of vision | <input type="checkbox"/> Short of breathe lying down | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Swollen ankles or feet | <input type="checkbox"/> Leaking urine |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Burning on urination |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Red or warm joints |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Green or yellow sputum | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Arm pain |
| <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Constipation | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Bad snoring | <input type="checkbox"/> Change in bowel function | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Change in voice | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Dark or tar looking stool | <input type="checkbox"/> Weakness of arms or legs |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Nervous exhaustion |
| <input type="checkbox"/> Swollen lymph glands | <input type="checkbox"/> Rashes | <input type="checkbox"/> Depression or anxiety |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Hives | <input type="checkbox"/> New moles or skin lesions |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Other |

Review of Systems :Women only check all that apply

None Apply

- | | | | |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> Irregular or missed periods | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Breast lumps or discharge |
|--|-----------------------------------|---|--|

Medical History: Check all that apply

- Heart attack
- Heart failure
- Angina (chest pain)
- High blood pressure
- Stroke
- Diabetes
- High cholesterol
- Rheumatoid arthritis
- Cancer of _____
- Osteoporosis
- Pneumonia
- Asthma
- Bronchitis
- Emphysema
- Lung disease
- Blood vessel disease
- Mental illness

None Apply

- Gout
- Ankylosing spondylitis
- Kidney stones
- Kidney failure
- Transplants
- Alcohol dependence
- AIDS
- Tuberculosis
- Other _____
- Hepatitis
- Lupus
- Blood clots in legs
- Blood clot in lungs
- Stomach ulcers
- Bleeding disorders
- Sickle Cell Disease
- Liver trouble

Surgical History:

None

Operation	Surgeon	Location	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History : Check all that apply

None Apply

Condition	Which Family Member	Condition	Which Family Member
<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Spine problems	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Kidney failure	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Osteoporosis	_____	<input type="checkbox"/> Bleeding disorders	_____
<input type="checkbox"/> Rheumatoid arthritis	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Osteoarthritis	_____	<input type="checkbox"/> Alcohol dependence	_____
<input type="checkbox"/> Lupus	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Sickle Cell	_____	<input type="checkbox"/> Other (list) _____	_____

Medications you take:

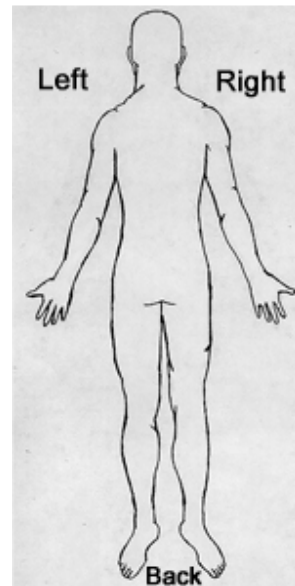
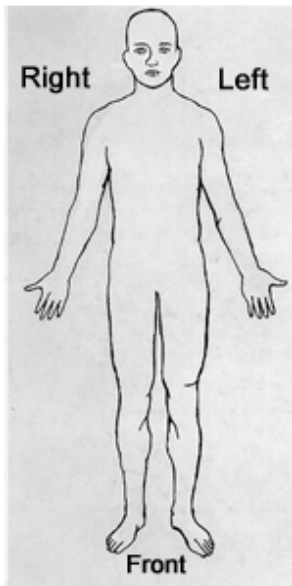
 None

Medication	Dose	How often	Reason for taking	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

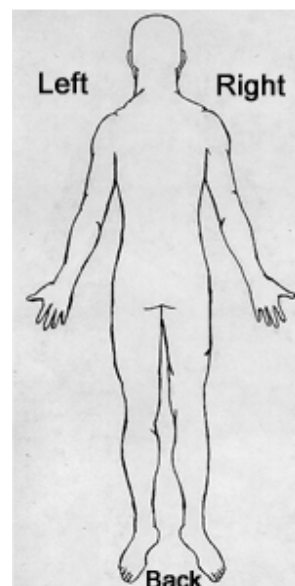
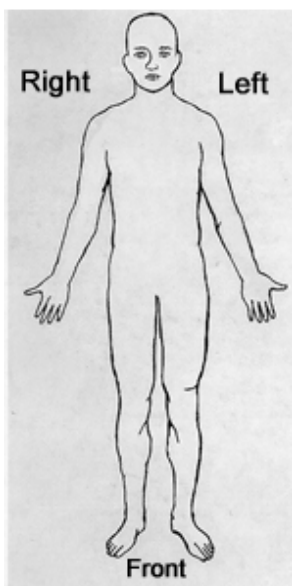
Write on the back of this form if more medications

Shade in where you are having pain.

___ Does not Apply



Draw the location of any other symptoms related to your problem. ___ Does not apply
Numbness / Tingling xxxxx Weakness oooo Other ++++ (list) _____



Allergies to Medications: *Check all that apply*

No Known Allergies

Medication	Rash	Wheezing	Swelling	Upset Stomach	Shock	Other (list)
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History: *Check all that apply*

Work Status

Occupation _____

Veteran _____

Homemaker

Not working

Student

Working

Retired

Disabled

Marital Status

Married

Single

Divorced

Widowed

Co-habiting

I Live: alone with _____

Alcohol Use

Never

Rare

Frequent

Drinks/week _____

Alcohol Dependent

Recovered Alcoholic

Drug Use

Never

Past

Currently _____

Tobacco Use *Check all that apply*

Never

Cigarettes

Cigars

Chew

Pipe

I have smoked _____ packs of cigarettes per day for _____ years total.

(If less than one pack) I have smoked _____ cigarettes per day for _____ years total.

I have smoked _____ cigars per day for _____ years total

I have chewed tobacco for _____ years total.

I have smoked a pipe for _____ years total.

I Quit _____ chewing _____ smoking _____(date)

My signature confirms I have answered the above questions to the best of my ability.

Patient/Guardian Signature _____

(if under 18)

Date _____