ORTHOPEDIC HEALTHCARE ASSOCIATES, INC.
MEDICAL AND SURGICAL HISTORY FORM

Date:_____

Name:_____SS#_____

Sex: M F Age:_____Date of Birth:_____/_____/_____

MEDICAL INFORMATION:

Reason for this visit: ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other_____

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

Have you had any X-rays, MRI, CT SCAN done? Y N If yes, where were they done?_____

Latex Allergy? ☐ Y ☐ N Have you seen any other orthopedist? ☐ Y ☐ N

What body part is involved? (Please mark the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

How long ago did it start? _____Days _____ Weeks _____ Months _____Years

Have you had a problem like this before? ☐Y ☐N

Please check the **ONE BOX** which best describes **how your problem started,** and answer questions below the box you checked. Use the space to the right if needed.

☐ **NO INJURY** (or onset was: ☐Gradual or ☐Sudden) **PLACE OF INJURY:** ☐Home ☐School ☐Auto ☐Other_____
Please indicate why you think it started?

☐ **INJURY** (☐ Accident ☐Sport) (NOT Auto or Work)
Date:_____ Please state where and how it happened
_____

What sport?_____ School related? ☐Y ☐N

☐ **INJURY AT WORK** Date:_____

From a: ☐Lift ☐Twist ☐Fall ☐Bend ☐Pull ☐Reach

☐ **WORK RELATED** (BUT NO INJURY)
Date:_____ How did your job cause the problem?

☐ **AUTO ACCIDENT**
Date:_____ How was your car hit?

COMMENTS:
_____
_____
_____
_____
_____
_____
_____
_____

On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning

The pain is: ☐Constant ☐Come and goes (intermittent)

Does your pain wake you from sleep? ☐Y ☐N

Since my problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged

What makes your symptoms worse? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐Lying in bed
☐Bending ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Coughing ☐Sneezing

What makes your symptoms better? ☐Rest ☐Elevation ☐Ice ☐Heat ☐Other_____

PLEASE COMPLETE PAST HISTORY FORM ON REVERSE SIDE

PAST MEDICAL AND SURGICAL HISTORY

ALL MEDICATIONS (include dosage) ☐**No meds taken**	**ALLERGIES (**Please list all) ☐**No Allergies**

PAST MEDICAL HISTORY (Check all that apply)	**PAST SURGICAL HISTORY** (Check all that apply)
□□ High Blood Pressure □ □Heart Disease □Gout □□ High Cholesterol □ □Diabetes □□ Lung Disease □ □Thyroid Disease □□ Kidney/renal Disease □ □History of blood clots □□ Bleeding Disorder □ □History of MRSA □ Other_____ □ Other_____	□ □Heart By-pass □ □Rotator Cuff Repair □ □Vascular Surgery □Carpal Tunnel □ □Hysterectomy □ □Arthroscopy □ □Knee Replacement □ □Spine Surgery □ □Hip Replacement □ □Other_____ □ □Other_____
CARDIOVASCULAR	**RESPIRATORY**
□ □Heart attack □ □Pacemaker/defibrillator □ □Heart murmur □ □Palpitations □ □Chest Pain or angina □ □Aneurysm □ □Arrhythmia/irregular beats □ □Edema (swelling of feet or ankles) □ □Shortness of breath □ □Other_____ □ □None of the above/negative	□ □Asthma or wheezing □ □Frequent or chronic cough □ □COPD (emphysema) □ □Tuberculosis □ □Coughing up blood □ □Coughing up phlegm □ □History of lung cancer □ □Other_____ □ □None of the above/negative
NEUROLOGIC	**GASTROINTESTINAL**
□ □Stroke □ □Paralysis □ □Seizures □ □Dizziness □ □Numbness/tingling □ □Speech difficulties □ □Migraine headache □ □Other_____ □ □None of the above/negative	□ □**Reflux** □ □**Ulcers** □ □**Heartburn** □ □Hepatitis □ □Colitis □ □Irritable bowel syndrome □ □Abdominal pain □ □Bloody stool □ □Cancer □ □Other_____ □ □None of the above/negative
GENITOURINARY	**MUSCULOSKEKETAL**
□ □Urinary tract infection □ □Kidney stones □ □Prostate disease □ □Urinary incontinence □ □Other_____ □ □None of the above/negative	□ □Rheumatoid disease □ □Arthritis □ □Fibromyalgia □ □Lupus □ □Joint pain/stiffness/swelling □ □Other_____ □ □None of the above/negative

Do you smoke? Y N #packs/day?_____ **Do you drink alcohol? Y N How much?_____**

Have you ever been treated for any kind of cancer? Y N What kind of cancer did you have?_____

Ht:_____ **Weight:_____**

Do you have a history of any blood transmitted diseases such as HEPATITIS or HIV? Y N

PRIMARY CARE PHYSICIAN:_____

List all other current doctors:_____

THIS INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE:

Patient Signature:_____Date___/____/_____

MD REVIEWED:_____Date___/____/_____