Orthopedic Initial History Survey

Date:_____ Chart # _____ Provider _____

Patient Name (Please Print) _____ DOB___/_____/___ Temp _____ H _____/_ W _____

Age ____ ❒F ❒M Height ___/___ Weight _____ Did you bring x-rays? ❒Y ❒N Labs ❒Y ❒N

Who requested that you visit this office? ❒Doctor (Name)_____ ❒ Self-Referral ❒Attorney_____

What is the main reason for this visit? (Chief Complaint) _____

What body part is involved? (Location)															
Neck	❒	Shoulder	❒R ❒L	Elbow	❒R ❒L	Hand	❒R ❒L	Pelvis	❒R ❒L	Knee	❒R ❒L	Foot	❒R ❒L
Back	❒Mid ❒Lower	Arm	❒R ❒L	Wrist	❒R ❒L	Finger	❒R ❒L	Hip	❒R ❒L	Ankle	❒R ❒L	Toe	❒R ❒L

How long has this problem been present?_____❒Days ❒Weeks ❒Months ❒Years

Are you right or left handed? ❒Right ❒Left

Did you have an injury? ❒Yes ❒No If so, was it…

At work? ❒Yes ❒No

In a motor vehicle accident? ❒Yes ❒No

Other type of injury?_____

Date of Injury?_____

Litigation pending? ❒Yes ❒No

Was onset: ❒ **Gradual or** ❒**Sudden ANSWER:** _____

Please check the box below which best describes your problem:

The pain is ❒Constant ❒Comes and goes (Intermittent)

Severity of pain ❒Mild ❒Moderate ❒Severe ❒Extremely Severe

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

❒Other:_____

Are there **associated symptoms**? ❒Swelling ❒Numbness ❒Weakness

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

Does your pain wake you from your sleep? ❒Yes ❒No

What makes your symptoms **worse**? ❒Activity ❒Exercise ❒Work

❒Other_____

Which makes you feel better? ❒Rest ❒Heat ❒Ice ❒Elevation

❒Other_____

Do you have any of the following? ❒Fever ❒Chills ❒Sweats

Do you have difficulty in controlling your bowels or bladder? ❒Yes ❒No

Check which treatments you have tried for today's problem:

❒Injection ❒Brace ❒Therapy ❒Cane/Crutch ❒Chiropractor ❒Orth

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PREVIOUS INJURIES

1) Have you had prior problems with this same orthopedic condition in the past? ❒Y ❒

If yes, when?_____

What Diagnostic tests have you had for this problem?

❒X-rays ❒Bone Scan ❒Myelogram

❒EMG/NCS ❒Dexa Scan ❒CT Scan

PAST MEDICAL HISTORY: ❒ **None**

2) Do you have any of the following Medic al Problems? Please check the ones that app

AIDS/HIV	❒	Bleeding Problems	❒	COPD	❒	Stroke	❒
Migraines	❒	Emphysema/Asthma	❒	Hepatitis A,B,C	❒	Polio	❒
Anemia	❒	Fibromyalgia	❒	Osteoporosis	❒	Stomach Prob.(Ulcers,Reflux)	❒
Arthritis	❒	Heart Problems	❒	Nerve Probs.	❒	Thyroid Problems	❒
Diabetes	❒	Kidney Problems	❒	Pneumonia	❒	Blood Clots (DVT,PE)	❒
Epilepsy	❒	High Blood Pressure	❒	Psychiatric Disorders	❒	Rheumatoid Arthritis	❒
Gout	❒	Muscle Diseases	❒	Depression/Anxiety	❒	❒Other/None_____	
Cancer	❒	**Type:** ❒Breast ❒Prostate ❒Lung ❒Thyroid ❒Myeloma _____					

PAST SURGICAL HISTORY ❒ **None**

3) Have you had any of the following surgeries? Please check the ones that apply and give the date

Arthroscopy	❒Left ❒Right	❒Ankle ❒Knee ❒Shoulder ❒ Wrist	❒___/___
Replacement	❒Left ❒Right	❒Ankle ❒Knee ❒Shoulder ❒Hip ❒Elbow	❒___/___
Fracture Fixation	❒Left ❒Right	❒Ankle ❒Calcaneus ❒Elbow ❒Femur ❒Foot ❒Forearm ❒Shoulder ❒Hip ❒Tibia ❒Wrist	❒___/___

ACL Reconstruction	❒___/___	Cervical Fusion	❒___/___	Lumbar Fusion	❒___/
Brain Surgery	❒___/___	Hand Surgery	❒___/___	Pacemaker	❒_____/
Breast Surgery	❒___/___	Intramedullary Nail Femur	❒___/___	Splenectomy	❒_____/
Cardiac Stent	❒___/___	Intramedullary Nail Tibia	❒___/___	Thoracic Fusion	❒___/___
Cardiac Surgery	❒___/___	Thoracic Discectomy	❒___/___	_____	❒___/___
Carpal Tunnel	❒___/___	Lumbar Discectomy	❒___/___		

SOCIAL HISTORY

Do you use tobacco? ❒Y ❒N **Packs per day**_____ Smokeless varieties_____

Alcohol use? ❒Y❒N How often? ❒ Daily___/Week

Marital History: M S D W How many people live with you? _____

Are you currently working? ❒Y ❒N ❒Retired

Occupation:_____ ❒Student

Employer:_____ If not working, how long have you been off work?_____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

* Any direct relative with the same Orthopedic condition you are being seen for today? ❒Y ❒N_____

Diabetes ❒Y ❒N_____ High Blood Pressure ❒Y ❒N_____ Heart Disease ❒Y ❒N_____

Blood Clots ❒Y ❒N Arthritis ❒Y ❒N_____ Cancer ❒Y ❒N If yes, Type: _____

REVIEW OF SYSTEMS: Do you <u>currently</u> have any of the following medical symptoms? Please check those that apply.

Chest Pain	❒	Constipation	❒	Abnormal Bleeding	❒	Abnormal Menstrual Cycle	❒
Cough	❒	Cold Hands/Feet	❒	Growth Disturbance	❒	Incontinence of Bowel	❒
Depression	❒	Loss of Appetite	❒	Runny Nose	❒	Incontinence of Urine	❒
Ear Pain	❒	Muscle Weakness	❒	Numbness of Feet	❒	Sleep Disturbance	❒
Fainting	❒	Impotence	❒	Numbness of Hands	❒	Sputum Production	❒
Fever	❒	Balance Problems	❒	Shortness of Breath	❒	Visual Disturbance	❒
Mania	❒	Seizures	❒	Sore Throat	❒	Swelling in the Legs	❒
Skin Rash	❒	Skin Ulcers	❒	Wheezing	❒	Unexplained Weight Loss	❒
Vomiting	❒	Stomach Pain	❒	Weight Gain	❒	Other_____	
					❒	**None**	

Are you independent in normal daily activities? Yes/No Has this changed recently? Yes/No

Current Medications:	Dosage		Dosage

❒ **Pharmacy Name & Number:**

Medication Allergies: ❒Y ❒N **If yes, please list:** _____

Have you ever had a reaction to anesthesia? ❒Y ❒N

Patient Signature:_____ Date__/__/_ Reviewed by MD Date__/__/_

Reviewed by MD_____ Date__/__/_ Reviewed by MD Date__/__/_