

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 <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, was it...
At work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
In a motor vehicle accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other type of injury?	_____		
Date of Injury?	_____		
Litigation pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was onset:	<input type="checkbox"/> Gradual or <input type="checkbox"/> 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 Orthotics Other _____

PREVIOUS INJURIES			
1) Have you had prior problems with this same orthopedic condition in the past? <input type="checkbox"/> Y <input type="checkbox"/> N (explain below)			
If yes, when? _____			
What Diagnostic tests have you had for this problem?			
<input type="checkbox"/> X-rays	<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Myelogram	<input type="checkbox"/> MRI
<input type="checkbox"/> EMG/NCS	<input type="checkbox"/> Dexa Scan	<input type="checkbox"/> CT Scan	<input type="checkbox"/> Other _____

PAST MEDICAL HISTORY: <input type="checkbox"/> None			
2) Do you have any of the following Medical Problems? Please check the ones that apply			
AIDS/HIV <input type="checkbox"/>	Bleeding Problems <input type="checkbox"/>	COPD <input type="checkbox"/>	Stroke <input type="checkbox"/>
Migraines <input type="checkbox"/>	Emphysema/Asthma <input type="checkbox"/>	Hepatitis A,B,C <input type="checkbox"/>	Polio <input type="checkbox"/>
Anemia <input type="checkbox"/>	Fibromyalgia <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	Stomach Prob.(Ulcers,Reflux) <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Heart Problems <input type="checkbox"/>	Nerve Probs. <input type="checkbox"/>	Thyroid Problems <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Kidney Problems <input type="checkbox"/>	Pneumonia <input type="checkbox"/>	Blood Clots (DVT,PE) <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Psychiatric Disorders <input type="checkbox"/>	Rheumatoid Arthritis <input type="checkbox"/>
Gout <input type="checkbox"/>	Muscle Diseases <input type="checkbox"/>	Depression/Anxiety <input type="checkbox"/>	<input type="checkbox"/> Other/None _____
Cancer <input type="checkbox"/>	Type: <input type="checkbox"/> Breast <input type="checkbox"/> Prostate <input type="checkbox"/> Lung <input type="checkbox"/> Thyroid <input type="checkbox"/> 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	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Ankle <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist	<input type="checkbox"/> _/_/___
Replacement	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Ankle <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> Elbow	<input type="checkbox"/> _/_/___
Fracture Fixation	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Ankle <input type="checkbox"/> Calcaneus <input type="checkbox"/> Elbow <input type="checkbox"/> Femur <input type="checkbox"/> Foot	<input type="checkbox"/> _/_/___
		<input type="checkbox"/> Forearm <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> Tibia <input type="checkbox"/> Wrist	
ACL Reconstruction	<input type="checkbox"/> _/_/___	Cervical Fusion	<input type="checkbox"/> _/_/___
Brain Surgery	<input type="checkbox"/> _/_/___	Hand Surgery	<input type="checkbox"/> _/_/___
Breast Surgery	<input type="checkbox"/> _/_/___	Intramedullary Nail Femur	<input type="checkbox"/> _/_/___
Cardiac Stent	<input type="checkbox"/> _/_/___	Intramedullary Nail Tibia	<input type="checkbox"/> _/_/___
Cardiac Surgery	<input type="checkbox"/> _/_/___	Thoracic Discectomy	<input type="checkbox"/> _/_/___
Carpal Tunnel	<input type="checkbox"/> _/_/___	Lumbar Discectomy	<input type="checkbox"/> _/_/___
		Lumbar Fusion	<input type="checkbox"/> _/_/___
		Pacemaker	<input type="checkbox"/> _/_/___
		Splenectomy	<input type="checkbox"/> _/_/___
		Thoracic Fusion	<input type="checkbox"/> _/_/___
			<input type="checkbox"/> _/_/___

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 currently have any of the following medical symptoms? Please check those that apply.

Chest Pain	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Abnormal Menstrual Cycle	<input type="checkbox"/>
Cough	<input type="checkbox"/>	Cold Hands/Feet	<input type="checkbox"/>	Growth Disturbance	<input type="checkbox"/>	Incontinence of Bowel	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	Incontinence of Urine	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Numbness of Feet	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	Numbness of Hands	<input type="checkbox"/>	Sputum Production	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Visual Disturbance	<input type="checkbox"/>
Mania	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	Swelling in the Legs	<input type="checkbox"/>
Skin Rash	<input type="checkbox"/>	Skin Ulcers	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Unexplained Weight Loss	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	Other _____	
					<input type="checkbox"/>	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 ___/___/___