BONE & JOINT SPECIALISTS
ORTHOPEDIC CENTER
Specializing in Arthroscopic Surgery, Hand Surgery, Foot & Ankle Surgery,
Joint Reconstruction, Sports Medicine, Podiatry, Workers Compensation

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PATIENT HISTORY

Date: _____/_____/_____ Referred by: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Sex: ○ M ○ F Age: _____ Hand Dominance: ○ R ○ L **Occupation:** _____

PRESENT ILLNESS

Reason for Visit: _____ **Date of onset/injury:** _____/_____/_____

Mechanism of injury: _____

PAIN: Where does it hurt: _____

Describe the pain: _____

Severity (1-10, 10 being very severe): _____

How often: _____

How has it changed over time: _____

What makes it better: _____

What makes it worse: _____

Associated symptoms: _____

PRIOR TREATMENT: Physician: _____

Medications: _____

Injections: _____

Therapy: _____

Tests/Imaging: _____

Occupational Injury ○ Y ○ N Work Missed: ○ Y ○ N

Last Date Worked: _____/_____/_____ Date Returned to Work: _____/_____/_____ with full / light duty

Pharmacy Name and Location: _____

List all current medications: _____

_____

_____

Are you claustrophobic? ○ Mild ○ Moderate ○ Severe ○ No

Drug Allergies and Reaction: _____

_____

Anesthesia Complications: _____

Date: _____/_____/_____ Patient Name: _____

PAST MEDICAL HISTORY Check all that apply

CV: O Heart Attack O Chest pain O Congestive Heart Failure O Arrhythmia O High Blood Pressure O Heart Murmur O Varicosities O Blood Clots

Respiratory: O Asthma O Emphysema O Chronic Bronchitis O Pneumonia O Asbestos

GI: O Ulcers O Esophagitis O Gastritis O Hiatal Hernia O Hepatitis O GERD

Renal: O Kidney Infections O Kidney Failure O Kidney Stones O UTI

Cancer: _____

Hematologic: O Anemia O Hemophilia O Other Bleeding Disorder _____

Endocrine: O Hypo Thyroidism O Hyper Thyroidism O Diabetes O Pituitary Gland Disorder

Rheumatologic: O Gout O Rheumatoid Arthritis O Lupus O Scleroderma O Rheumatic Fever O Psoriasis O Fibromyalgia

DVT Risk Factors: O Varicosities O Heart Disease O HBP O Obesity O Stroke O Previous Blood Clot O Diabetes

History of MRSA O Y O N **or Staph Infection** O Y O N

PAST SURGICAL HISTORY Please list

_____ _____

_____ _____

_____ _____

FAMILY HISTORY Please include mother, father, siblings, grandparents

Anesthesia Complications: _____

Cardiovascular: _____

Cancer: _____

Hematologic: _____

Musculoskeletal: _____

Renal: _____

Diabetes/Thyroid problems: _____

SOCIAL HISTORY

Tobacco: O Current O Nonsmoker O Former _____ years quit

Alcohol: O Frequent O Social O Occasional O Rare O None

Illicit Drug Use: Type _____ Amount _____ Frequency _____

Do you have any personal preferences/beliefs that would prevent you from receiving a blood transfusion? O Y O N

REVIEW OF SYSTEMS Check all that apply

Constitutional: O Chills O Fevers O Night Sweats O Weight Loss O Weight Gain

Eyes: O Near-Sightedness O Far-sightedness O Astigmatism O Double Vision O Glaucoma

Ears: O Hearing loss O Tinnitus O Vertigo

Nose, Mouth, Throat: O Rhinorrhea O Congestion O Sore Throat

CV: O Chest Pain O Heart Palpitations O Edema

Respiratory: O Cough O Wheezing O Difficulty Breathing O Coughing Blood O Shortness of Breath

GI: O Nausea O Heartburn O Bowel Irregularities O Hemorrhoids

GU: O Frequency O Hesitancy O Blood in Urine O Incontinence O Irregular Menstrual Cycle

Musculoskeletal: O Muscle Aches O Joint Swelling O Neck Pain O Back Pain

Integumentary: O Skin lesions: O Stable O Changing O Acne O Rashes

Neurological: O Headaches O Loss of Consciousness O Seizures O Tingling O Numbness O Gait Disturbance

Psychiatric: O Depression O Mood-swings O Hallucinations O Anxiety

Endocrine: O Excessive Thirst O Frequent Urination O Hyperactivity O Difficulty Sleeping

Hematologic: O Easy Bruisability O Anemia O Bloody Noses O Excessive Blood Loss O HIV Risk

Height: _____ **Weight:** _____