Welcome to University Orthopedics !

In order to provide you with the best possible care, please complete all the information on this form.
This form is part of your medical record, so **complete every line in all the sections**, then please **sign the form**.

(1) PATIENT NAME: _____ **Date of Birth:** _____ **Age:** _____
Home Phone: _____ **Cell Phone:** _____
May we leave a message on your phone(s) if needed? (Yes / No)

(2) CHIEF COMPLAINT: Please describe your chief complaint, current symptoms or problem:

_____
_____
_____

Which side does this affect? (LEFT – RIGHT – BILATERAL) **When did this begin?** _____
How were you referred to our practice? _____

INJURY:

- **Did you have a specific injury? (Yes / No)** **Describe it briefly:** _____
- **Date & Place of Injury:** _____ **Is it work related? (Yes / No) [Worker's Comp. Case #:** _____**]**
- **Was this caused by a car accident? (Yes / No)** **Is your injury currently involved in legal action? (Yes / No)**

SYMPTOMS: Circle all that apply:

- What makes it **better**? (Rest, Ice, Heat, NSAIDS, Tylenol, Narcotic, Cortisone Injection, Bracing, Cane, Crutches, Therapy)
- What makes it **worse**? (Work, Walking, Standing, Stairs, Other: _____)
- Have you ever had **surgery** for this problem? (Yes / No): _____
- **Rate your pain on this scale:** [(none) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (severe)]
- **Pain Description**: (Sharp – Dull – Burning – Constant – Intermittent – Occasional – Sudden – Worsening – Improving)

(3) REVIEW OF SYSTEMS: Circle any current problems on each line below.

☐ **Constitutional:** Fevers - Chills - Weight Loss - Fatigue	☐ **Skin:** Itching – Lumps – Rashes – Blisters - Ulcers
	☐ **Musculoskeletal:** Joint pain – Swelling - Stiffness
☐ **Eyes:** Blindness - Blurriness - Cataracts	☐ **Neurologic:** Dizziness – Numbness – Tingling – Tremors
☐ **Ear/Nose/Throat:** Hearing loss – Ringing - Nosebleeds	☐ **Psychiatric:** Nervousness – Depression – Memory Loss
☐ **Cardiovascular:** Chest Pain - Tightness - Palpitations	☐ **Endocrine:** Excessive Thirst – Frequent Urination
☐ **Respiratory:** Cough – Wheezing – Shortness of Breath	☐ **Hematologic:** Easy Bruising – Easy Bleeding
☐ **Gastrointestinal:** Heartburn - Nausea - Reflux - Rectal Bleeding	☐ **Immunologic:** Severe Allergy - Frequent infections
☐ **Genitourinary:** Frequency - Urgency – Incontinence	

(4) ALLERGIES: -- Do you have a **LATEX ALLERGY? (YES or NO)**
List any medication(s) allergies and your reaction(s): _____

_____

_____

(5) GENERAL HEALTH QUESTIONS:

- Do you have **Sleep Apnea?** (Yes / No)
- Hand Dominance: (Right / Left)
- Have you ever had an **Infection** with: **MRSA**? (Yes / No) **VRE**? (Yes / No) **C-DIFF**? (Yes / No)
- **If Female, Are You Pregnant?** (Yes / No)
- **Preventative Medicine:**
  - If Known, List Dates of Most Recent: **Influenza Vaccine:** _____ **Pneumonia Vaccine:** _____
  - **Have you had any of the following tests? Please list any abnormal findings.**
    - **Colonoscopy:** _____
    - **Pap Smear:** _____
    - **Mammogram:** _____
    - **Bone Density Testing:** _____

(6) LIST YOUR DOCTORS and their addresses. **Should we send them a copy of your office note after your visit? (Yes / No)**

Your Primary Care Physician:	**Your Other Medical Doctors:**	
1) Dr._____	2) Dr._____	3) Dr._____
Address:_____	Address:_____	Address:_____
_____	_____	_____
_____	_____	_____
Phone:_____	Phone:_____	Phone:_____

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(7) MEDICAL HISTORY: Circle any known problems below: **YOUR HEIGHT:** **YOUR WEIGHT:**

NEURO:	Migraines	TIA/Stroke	Visual Problems	Seizures	Nerve Injury
ENDOCRINE:	Thyroid (Hi/Low)	Menopause	Diabetes (Type I or II?)	Obesity	High Cholesterol
RESPIRATORY:	Asthma	Emphysema	COPD	Pneumonia	Pulmonary Fibrosis
CARDIAC:	Valve Replacement	Murmur	Atrial Fibrillation (AFIB)	Heart Attack	High Blood Pressure
GI:	GERD	Stomach Ulcer	Colitis	High Cholesterol	
VASCULAR:	Bleeding Problems	Blood Clots	Pulmonary Embolism	Anemia	Peripheral Vascular Disease
ORTHO:	Osteoarthritis	Rheumatoid	Gout / Pseudogout	Fibromyalgia	Osteoporosis
PSYCH:	Depression	Anxiety	Bipolar Disorder	Panic Disorder	OCD
IMMUNE:	Lupus	HIV	HEPATITIS (A, B, or C)?		
CANCER:	**Type:** _____	Surgery/Radiation/Chemotherapy:_____			

LIST ANY OTHER MEDICAL CONDITIONS:_____

(8) SURGICAL HISTORY: List ALL prior surgeries below:

Tonsils	Eye	Ear/ Nose/Throat	Thyroid	Cosmetic	Pacemaker	Hernia
Breast	Lung	Heart (CABG)	Gallbladder	Vascular	Spine: _____	
Appendectomy	Stomach/ Bowel	Gastric Bypass	Prostate (TURP)	Hysterectomy	Other: _____	

LIST ALL PRIOR ORTHOPAEDIC SURGERIES: _____

_____

_____

(9) MEDICATIONS: List all prescription & OTC meds (with dosages) and vitamins. We can copy a detailed list if you have one.

1) _____	5) _____	9) _____
2) _____	6) _____	10) _____
3) _____	7) _____	11) _____
4) _____	8) _____	12) _____

(10) SOCIAL HISTORY:

Your Current (or Former) Occupation: _____ **Employer**: _____
Current Work Status: (Full Duty - Light Duty - Sedentary - Not Working - Disabled - Retired)
If you are not working: When was the last time you worked? _____

- Marital Status: (Single – Married – Divorced – Widowed) Who do you live with? _____
- Your home: (Condo – Apartment – House – Nursing/Rehab Center) Are you safe living in your home? (Yes / No)
- Hobbies: _____ Sport & Exercise: _____
- Alcohol Intake & Frequency: _____ Tobacco: _____ packs per day for ____ years
- Special Diet? _____ Highest Level of Education: _____

(11) FAMILY HISTORY: List any known cancers, causes of death, immune diseases, bleeding disorders, or joint problems in your:

- Parents: _____
- Siblings: _____
- Children: _____
- Other Relatives: _____

(12) ADDITIONAL INFORMATION

Is there any other information that you would like to tell your provider: _____

_____

_____

Who is with you today for your visit? _____
Who is your Emergency Contact Person: _____ Home #: _____ Cell #:_____

PATIENT: The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient Signature _____ **Visit Date:**_____

PROVIDER: I have reviewed and updated each section of this form with the patient.

Provider Signature _____ **Date Updated:**_____

Form Updated: November 2012