The Centers for Advanced Orthopaedics
The Orthopaedic Center Division

Date of Birth:

Appointment Date:

Patient Medical History

*** Please return completed paperwork to the clinic technician ***

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Height: _____ inches Weight: _____ lbs

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

When did the problem start (if there was an injury, what date did it occur)? _____

If there was an injury, how did it occur? _____

Current problem is a result of ?: ☐ Car Accident ☐ Work Accident ☐ Other (specify) _____

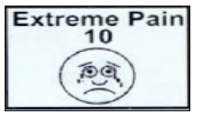
Have you ever been treated for this problem before? ☐ No ☐ Yes If yes,when and where? _____

What teatments have you received for **THIS SPECIFIC PROBLEM** (Select all that apply)? _____

☐ Physical Therapy ☐ Injections _____ ☐ Surgery (What and When)? _____ ☐ Other: _____

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1 -10.

1	2	3	4	5	6	7	8	9



MEDICAL HISTORY

Are you currently receiving treatment or have you previously received treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	DVT / Blood Clots	☐	☐	Kidney Problems	☐	☐	Psychological problems
☐	☐	Anxiety	☐	☐	Epilepsy	☐	☐	Liver Disease			List: _____
☐	☐	Arthritis	☐	☐	Gallbladder Problems	☐	☐	Lung Problems	☐	☐	Pulmonary Embolism
☐	☐	Asthma	☐	☐	Gout	☐	☐	Phlebitis	☐	☐	Rheumatic Fever
☐	☐	Birth Defetcs	☐	☐	Heart Disease	☐	☐	MRSA / Staph Infection	☐	☐	Sexually Transmitted Disease
☐	☐	Bladder Problems	☐	☐	Hepatitis A B C	☐	☐	Osteoporosis	☐	☐	Stroke / TIA
☐	☐	Bleeding or Bruising	☐	☐	HIV / AIDS	☐	☐	Peripheral Vascular Disease	☐	☐	Tuberculosis
☐	☐	Cancer Type: _____	☐	☐	High Blood Pressure				☐	☐	Thyroid Problems
☐	☐	Depression	☐	☐	High Cholesterol	☐	☐	Polio	☐	☐	Ulcer Type: _____
☐	☐	Diabetes	☐	☐	Intestinal / Bowel Problems						

Are there any other medical problems we should know about? _____

Are you right or left-hand dominant? ☐ Right ☐ Left

Are you or could you be pregnant? ☐ Yes ☐ No

Do you exercise or participate in sports regularly? ☐ Yes ☐ No

Type and Frequency: _____

*** Pharmacy:** _____ **Location:** _____

MEDICATIONS

Please list all medications you take with or without a prescription (use extra paper if needed)

Medication Name	Dosage / # per day	Reason for taking

ALLERGIES

Please describe any current or past allergic reactions

Allergy to (drug)	Reaction (itching, cough, hives, etc)	How was / is the reaction treated?

☐ I DO NOT have any allergies

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SURGERIES AND HOSPITALIZATIONS

☐ Arthroscopy _____ Year _____ Physician _____ Complication? _____
☐ Joint replacement _____ Year _____ Physician _____ Complication? _____
☐ Bone or joint reconstruction _____ Year _____ Physician _____ Complication? _____
☐ Spine surgery _____ Year _____ Physician _____ Complication? _____
☐ Other general surgery _____ Year _____ Physician _____ Complication? _____
_____ Year _____ Physician _____ Complication? _____
☐ Other hospitalizations _____ Year _____ Physician _____ Complication? _____
☐ I HAVE NOT HAD any surgeries or hospitalizations

FAMILY HISTORY

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	Osteoporosis	Other _____
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Stroke	_____
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Sudden Death	_____

SOCIAL HISTORY

Do you smoke or chew tobacco? ☐ Yes ☐ No Number: _____ packs per day for _____ years
Do you drink alcoholic beverages? ☐ Yes ☐ No Amount and frequency: _____
Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: _____

REVIEW OF SYSTEMS

Please check the following symptoms you have experienced on a regular basis. If none, check NONE:

GENERAL
☐ Fever
☐ Weight change
☐ Hormonal problems
☐ Other _____
☐ NONE

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Fluid/ Swelling in extremities
☐ Other _____
☐ NONE

KIDNEY/ BLADDER
☐ Painful urination
☐ Frequent urination
☐ Incontinence
☐ Other _____
☐ NONE

EYES
☐ Glasses/ Contacts
☐ Cataracts
☐ Glaucoma
☐ Other _____
☐ NONE

RESPIRATORY
☐ Shortness of breath
☐ Sleep apnea
☐ Wheezing
☐ Other _____
☐ NONE

EARS, NOSE, THROAT
☐ Difficulty swallowing
☐ Ear pain
☐ Seasonal allergies
☐ Hard of hearing
☐ Other _____
☐ NONE

GASTROINTESTINAL
☐ Heartburn
☐ Diarrhea/ Constipation
☐ Abdominal pain
☐ Nausea/ vomiting
☐ Other _____
☐ NONE

SKIN
☐ Rashes
☐ Lumps
☐ Other _____
☐ NONE

HEMATOLOGIC/ LYMPHATIC
☐ Anemia
☐ Blood problems
☐ Clotting disorder
☐ Lymph Problems
☐ Other _____
☐ NONE

NEUROLOGICAL
☐ Headaches
☐ Numbness
☐ Tingling
☐ Seizures
☐ Weakness
☐ Other _____
☐ NONE

PSYCHOLOGICAL
☐ Anxiety
☐ Depression
☐ Mood swings
☐ Other _____
☐ NONE

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____