Orthopaedic Initial History Survey

Patient Name (please print) _____ Date: _____ Provider: _____

Chart # _____

Age _____ ☐ F ☐ M Height _____/_____ Weight _____

BP_____/_____ Pulse _____
Temp. _____ H____/____ W____

Who requested that you visit our office?
☐ Doctors (Name)_____ ☐Attorney _____

✸What is the main reason for your visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other _____(chief complaint)

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

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

Check the box which best fits <u>how your problem started</u>. Then answer the one question below the box you checked.

☐ **NO INJURY** (**Onset was**: ☐ Gradual or ☐ Sudden)
Why do you think it started?

☐ **INJURY** – (**Accident or Sport NOT Auto or Work**)
Date_____, Where and How did it Happen?
What sport _____ School _____

☐ **INJURY AT WORK**
Date _____, Where and How did it happen?

☐ **WORK RELATED – (BUT <u>NO</u> INJURY)**
Date _____, How did your job cause this problem?

☐ **AUTO ACCIDENT** Date _____, How was your car hit?

ANSWER:
_____
_____
_____
_____
_____
_____
_____
_____

Please check the box below which best describes your problem:

✸ The pain is ☐ Constant ☐ Comes and goes (Intermittent)

✸ **<u>Severity</u>** of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe

✸ What is the **<u>quality</u>** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other_____

Are there **<u>associated symptoms</u>**? ☐ Swelling ☐ Numbness ☐ Weakness

Since my problem started, it is: ☐ Getting better ☐ Getting Worse ☐ Unchanged

Does your pain wake you from sleep: ☐ Yes ☐ No

What makes your symptoms **<u>worse</u>**? ☐ Activity ☐ Exercise ☐ Work ☐ Other_____

Which make you feel **<u>better</u>**? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other_____

What medications have you taken or been prescribed for this problem? _____

Check which treatments you have tried? Injection ☐ Y ☐ N Brace: ☐ Y ☐ N Therapy: ☐ Y ☐ N Cane/Crutch: ☐ Y ☐ N

✸ Minimum dictation required for New/Consult Level 3, 4, 5 or Established Level 3, 4, 5

OVER →

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REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

1) **M/S** ▪ Have you had a **prior** problem with this same Orthopaedic condition in the past? ☐ Yes ☐ No (explain)
_____

▪ Have you had prior ☐ Back Pain ☐ Joint Swelling ☐ Prior Fracture ☐ Arthritis _____

2) **GI** ▪ Do you have stomach ulcers ☐ Y ☐ N, Blood in Stool ☐ Y ☐ N**,** Stomach pain w/ anti-inflammatory pills: ☐ Y ☐ N
▪ Do you have reflux disease ☐ Y ☐ N

3) **HEM** ▪ Are you taking, or have you ever taken **BLOOD THINNERS? (**i.e., coumadin, plavix, aspirin) ☐ Y ☐ N Type?_____

▪ Do you have a history of Blood Clots or Pulmonary Embolisms? ☐ Y ☐ N Explain?_____

4) ▪ Do you suffer from any of the following? ☐ Easy bleeding ☐E asy bruising ☐ Anemia ☐ None

5) **ARE YOU A DIABETIC**? ☐ Y ☐ N **TREATMENT**: ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

(Please check any that apply, or mark None)		**NONE**	**Year**	**Explain Details/Comments**
6) **CON**	☐ Weight loss ☐ Loss of appetite ☐ Fever ☐ Cancer	☐	_____	_____
7) **EYE**	☐ Glasses ☐ Contacts ☐ Double vision ☐ Cataracts	☐	_____	_____
8) **ENT**	☐ Hearing loss ☐ Hoarseness ☐ Ringing in ears	☐	_____	_____
9) **CV**	☐ High Blood Pressure ☐ Heart Attack ☐ Blood Clots	☐	_____	_____
10) **RS**	☐ Asthma ☐ Cough ☐ Pneumonia ☐ Short of Breath ☐ TB	☐	_____	_____
11) **GU**	☐ Pain with Urination ☐ Blood in Urine ☐ Kidney Disease	☐	_____	_____
12) **SK**	☐ Skin Ulcers ☐ Rash ☐ Lumps	☐	_____	_____
13) **NEU**	☐ Seizures ☐ Stroke ☐ Balance Problem ☐ Headaches	☐	_____	_____
14) **PSY**	☐ Depression ☐ Nervousness ☐ Sleep Disorder	☐	_____	_____

PAST MEDICAL HISTORY

✷**What Medications do you take?** ☐ None Please list with dosage:_____
_____
_____

Are You Allergic to Any Medications? ☐Y ☐N If yes, please list _____

Past Hospitalizations (Not for surgery) ☐ None _____

Past Surgical History: What operations have you had? When? ☐ None _____
_____

Any complications with Anesthesia? ☐Y ☐N If yes, explain _____

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

✷Any direct relative with the same Orthopaedic condition you are being seen for today? ☐Y ☐N _____

Diabetes ☐ Y ☐ N _____ High Blood Pressure ☐ Y ☐ N _____ Heart disease ☐ Y ☐ N _____ Arthritis ☐ Y ☐ N _____

SOCIAL HISTORY:

✷Do you use tobacco? ☐ Y ☐ N **Packs per day** _____ Alcohol use? ☐ Y ☐ N **How often**? ☐Daily ☐Other_____/week
Marital History: **M** ☐ **S** ☐ **D** ☐ **W** ☐ How many people live with you? _____
Are you currently working? ☐ Y ☐ N If no, how long have you been off work? _____
Occupation: _____ ☐ Student Employer: _____

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Reviewed by MD _____ Date_____/_____/_____

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