# Orthopaedic Initial History Intake

Patient Name: ________________________________________ Date: ______________ Provider: _______________

Chart # __________________________

| BP_____/_____ Pulse __________ |
|---|
| Temp. ________ H____/____ W____ |

Age: _________ ☐ F ☐ M Height _____/_____ Weight _______

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

Are you right handed or left handed? ☐ Right ☐ Left ☐ Ambidextrous

✷What is the main reason for your visit? ☐Pain ☐Numbness ☐Weakness ☐Other___________**(chief complaint)**

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

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

**Check the box which best fits how your problem started. 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 NO 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)

✷ **Severity** of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe

✷ What is the **quality** of the 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 sleep: ☐Yes ☐No

What makes your symptoms **worse**? ☐Activity ☐Exercise ☐Work ☐Other_____________________

Which make you feel **better**? ☐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*

**NEXT PAGE** ⟶

**ROS:** Please check all symptoms you have experienced in the last MONTH. ☐ All ROS is Negative
**PMH:** Please check any of the conditions below which you have been diagnosed with. ☐ All PMH is Negative

| Musculoskeletal | | Gastrointestinal | | Eyes |
|---|---|---|---|---|
| **ROS** | **PMH** | **ROS** | **PMH** | **ROS** |
| ☐ Pain with walking | ☐ Rheumatoid arthritis | ☐ Blood in stool | ☐ GERD/Reflux Disease | ☐ Glasses/contacts |
| ☐ Limitation of motion | | ☐ Nausea/vomiting | ☐ Ulcers | ☐ Double vision |
| ☐ Myalgia/muscle aches | | ☐ Indigestion or heartburn | | |
| | | ☐ Stomach pain with NSAIDS | | |
| **Respiratory** | | **Cardiovascular** | | **ENT** |
| **ROS** | **PMH** | **ROS** | **PMH** | **ROS** |
| ☐ Persistent cough | ☐ Asthma | ☐ Irregular heart beat | ☐ Heart Attack/MI | ☐ Hearing loss |
| ☐ Shortness of breath | ☐ COPD | ☐ Swelling of feet/ankles/legs | ☐ Atrial fibrillation | ☐ Hoarseness |
| ☐ Wheezing | ☐ Pneumonia | ☐ Palpitations | ☐ Hypertension/High Blood Pressure | ☐ Ringing in ears |
| ☐ Recurrent upper respiratory infections | ☐ Sleep Apnea | ☐ Chest pain or discomfort | ☐ Pacemaker/Defibrillator | **PMH** |
| | ☐ Use C-PAP | | | ☐ Deafness |
| **Constitutional/General** | | **Hematology** | | **Skin/Int** |
| **ROS** | **PMH** | **ROS** | **PMH** | **ROS** |
| ☐ Weight loss | ☐ Cancer | ☐ Easy bleeding/bruising | ☐ Anemia | ☐ Rash |
| ☐ Loss of appetite | • Year:______ | ☐ Blood clotting problem | ☐ DVT | ☐ Lumps |
| ☐ Fever/chills | • Type:______ | ☐ Currently taking blood thinners:__________________ | ☐ Pulmonary Embolism | |
| | | | ☐ Ever taken blood thinners: ___________ | |
| **Genitourinary** | | **Endocrine** | | **Immunological** |
| **ROS** | **PMH** | **ROS** | **PMH** | **ROS** |
| ☐ Pain with Urination | ☐ Kidney Disease | ☐ Excessive thirst/fluid intake | ☐ Diabetes (insulin) | ☐ Sinus pressure |
| ☐ Blood in Urine | ☐ Liver Disease | ☐ Temperature intolerance | ☐ Diabetes (non-insulin) | |
| ☐ Difficulty urinating | | ☐ Feeling tired (fatigue) | ☐ Thyroid Disease | |
| **Neurological** | | **Psychological** | | |
| **ROS** | **PMH** | **ROS** | **PMH** | |
| ☐ Balance problem | ☐ Migraines | ☐ Nervousness | ☐ Anxiety Disorder | |
| ☐ Headaches | ☐ Seizures | ☐ Memory loss | ☐ Depression | |
| ☐ Numbness or tingling | ☐ Stroke | | ☐ Psychological Disorder | |

## SURGICAL HISTORY

Prior Non-Orthopaedic Operations: ☐ None ____________________________________________
Prior Orthopaedic Operations: ☐ None ____________________________________________

Complications with anesthesia: ☐ No ☐ Yes, reaction: ________________________________________

History of malignant hyperthermia? ☐ No ☐ Yes

Past Hospitalizations (not for surgery): ☐ No ☐ Yes: ________________________________________

## SOCIAL HISTORY

Smoking status: ☐Current ☐Former ☐Never Alcohol Use: ☐Not at all Daily:____ Weekly:____ Monthly:_____

Substance/IV Drug History: ☐None ☐Yes, type:_________________________________

How many people live with you: ______ Marital Status: **M S D W**

Are you currently working: ☐ Yes ☐ No Occupation:_________________ Employer:______________________

If not, how long have you been off work:___________ ☐Student Sports activity:__________________

Have you ever received the pneumococcal vaccine: ☐Yes ☐No

Have you had 2 or more falls or a fall with injury in the past year: ☐Yes ☐No

## FAMILY HISTORY

☐ All Negative

Anesthetic Reaction: ☐ Mother ☐ Father Diabetes: ☐ Mother ☐ Father
Arthritis: ☐ Mother ☐ Father High Blood Pressure: ☐ Mother ☐ Father

**FOR OFFICE USE ONLY**

Reviewed by MD ______________________________________ Date _____/______/_______