BASIN ORTHOPEDIC SURGICAL SPECIALISTS, P.A.

Medical History Form

(Please use black ink)

Patient Name: _____Appointment Date: _____ with Dr. _____

Age: _____ Sex: ☐ F ☐ M Height: _____ Weight: _____ Dominant hand: ☐ R ☐ L Did you bring X-rays? ☐ Y ☐ N

Who is your primary physician? (Name): _____ ☐ MD ☐ PA Date last seen? _____

What is the reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other _____

Latex Allergy? ☐ Y ☐ N

What body part is involved? (Please mark the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐	☐

How long ago did it start? _____ Days_____Weeks_____Months_____Years

Have you had a problem like this before? ☐ Y ☐ N

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ **NO INJURY** (or onset was: ☐ Gradual or ☐ Sudden)
Please indicate why you think it started?

☐ **INJURY** ☐ Accident ☐ Sport ☐ Auto Accident
Date: _____ Please specify where & how it happened.

What sport? _____ School? _____

☐ **INJURY AT WORK**
From a: ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach

☐ **WORK RELATED** (But NO INJURY)
Date: _____ How did your job cause the problem?

Comments:

_____

_____

_____

_____

_____

On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent)

Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel or bladder ☐ Locking/Catching ☐ Giving way

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

What makes your symptoms worse ? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

What makes your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other: _____

What medications are you taking now? _____

ALLERGIC TO ANY MEDICATIONS? ☐ Y ☐ N If yes, please list and describe reaction:

_____

Have you had any of these treatments? Injection: ☐ Y ☐ N Brace: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N Cane/Crutch: ☐ Y ☐ N

Were you seen in the E.R. for this problem? ☐ N ☐ Y If yes, which E.R.? _____ Date: _____

Are you here today as a result of an E.R. visit? ☐ N ☐ Y Who saw you in the E.R.? _____ ☐ MD ☐ PA

What test/scans have you had for this problem?

☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV) Where? _____

Have you already had surgery for a problem in this same area either recently or in the past? ☐ N ☐ Y

Please list below:

Procedure #1_____Surgeon:_____ City: _____ Date: _____

Procedure #2_____Surgeon: _____City: _____Date: _____

Current work status? ☐ Regular ☐ Light duty – (how long? _____) ☐ Not working due to this problem ☐ Disabled ☐ Retired ☐ Student

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: Disability: ☐ Y ☐ N Worker's Comp: ☐ Y ☐ N Unemployment: ☐ Y ☐ N

BASIN ORTHOPEDIC SURGICAL SPECIALISTS, P.A.

REVIEW OF SYSTEMS

Patient Name: _____

Have you had a prior problem with this same Orthopedic condition in the past? ☐ N ☐ Y (Explain below)

_____

Do your other joints have: ☐ Morning stiffness lasting over 30 minutes ☐ Joint pain or swelling ☐ Back Pain ☐ Gout
☐ Rheumatoid arthritis ☐ Osteoporosis ☐ Prior fracture (which bone)_____ ☐ None of these

Have you had any of these symptoms? If no, mark NONE		**NONE**	**YEAR**	**Details/Comments**
1. GI	☐ Heartburn, ulcers ☐ Nausea, Vomiting ☐ Blood in stool ☐ Hepatitis ☐ Liver Disease	☐	_____	_____
2. ENDO	☐ Thyroid Disease ☐ Heat or Cold Intolerance	☐	_____	_____
3. CON	☐ Weight Loss ☐ Loss of Appetite	☐	_____	_____
4. EYE	☐ Blurred Vision ☐ Double Vision ☐ Vision Loss	☐	_____	_____
5. ENT	☐ Hearing Loss ☐ Hoarseness ☐ Trouble Swallowing	☐	_____	_____
6. CV	☐ Chest Pain ☐ Palpitations	☐	_____	_____
7. RS	☐ Chronic Cough ☐ Shortness of Breath	☐	_____	_____
8. GU	☐ Painful Urination ☐ Blood in Urine ☐ Kidney Problems	☐	_____	_____
9. SK	☐ Frequent Rashes ☐ Skin Ulcers ☐ Lumps ☐ Psoriasis	☐	_____	_____
10. NEU	☐ Headaches ☐ Dizziness ☐ Seizures	☐	_____	_____
11. PSY	☐ Depression ☐ Drug/Alcohol Addiction ☐ Sleep Disorder	☐	_____	_____
12. HEM	☐ Easy Bleeding ☐ Easy Bruising ☐ Anemia	☐	_____	_____

13. ARE YOU HIV POSITIVE? ☐ N ☐ Y

PAST MEDICAL HISTORY

Are you Diabetic? ☐ N ☐ Y If yes, treatment? ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

Are you taking or have you ever taken blood thinners? ☐ N ☐ Y If Yes, which one?

_____

Past Surgical History: What operations have you had and when? Please list:

_____

_____

Have you or a family member ever had a reaction to anesthesia? ☐ N ☐ Y EXPLAIN: _____

Past Hospitalizations: (Not for surgery): _____ ☐ None

Have you ever had: ☐ Heart attack (Year_____) ☐ High Blood Pressure ☐ Blood Clots (Year_____) ☐ Stroke ☐ Heart Failure
☐ Ankle Swelling ☐ Kidney Failure ☐ Cancer (Type/location_____)

☐ Stomachache while taking anti-inflammatories (includes Advil/Aleve/Motrin). If yes, what anti-inflammatories have you already had a problem with?

_____

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

☐ Diabetes _____ ☐ High Blood Pressure _____ ☐ Rheumatoid Arthritis_____ ☐ NONE

Do any direct relatives have the same condition you are being seen for today? ☐ Y ☐ N

SOCIAL HISTORY:

Do you use tobacco? ☐ N ☐ Y If yes, packs per day?_____ How many years? _____ Patient informed of smoking risk? ☐ Y

Alcohol use? ☐ N ☐ Y If yes, how often? ☐ Daily ☐ Other _____/week

Marital History: ☐ M ☐ F ☐ S ☐ D ☐ W How many people live with you? _____

Occupation: _____ ☐ Student

Employer:

_____

Do you plan to be working 6 months from now? ☐ Y ☐ N

PLEASE SIGN: The information on this/these form(s) is accurate to the best of my knowledge.

_____

Signature **Date**

FOR OFFICE USE ONLY

Completed _____ Date_____

Review #1 by _____ MD Date: _____ Review #2 by _____MD Date: _____