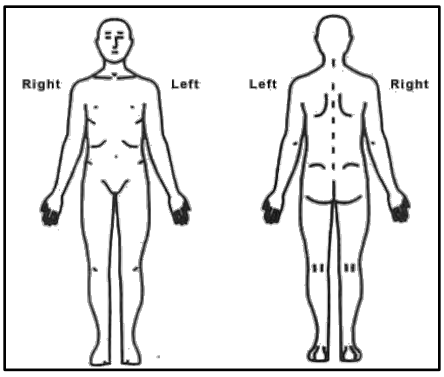
History Form
Orthopaedic Surgery

MUSCULOSKELETAL CENTER

Patient Name:_____ Age:_____ Height:_____ Weight:_____

Date of Birth:_____ Primary Care / Referring Physician: _____

What is the main reason for your visit: _____



1. On a scale of 0 to 10, what would you give your pain today? _____
2. Describe the quality of your pain, *please circle all that apply*:

Aching Gnawing Pressure Stinging Drilling Heaviness
Raw Throbbing Burning Hot Cold Tightness
Nagging Shock-like Sharp Exhausting Cramping Penetrating
Shooting Other: _____

3. Are you experiencing radiating pain? ___ Yes ___ No

If "yes", where does the pain radiate to: _____

4. How long has the current condition been present? _____

Date of onset: _____

5. How did the problem begin? Gradual onset Sudden onset After surgery Accident / Injury

Accident / Injury date: _____ Was the accident /injury work related? Yes No Automobile Related

Accident / Injury: Yes No Please describe the accident / injury:_____

6. Injury / Illness aggravated by: _____ Relieved by: _____
7. Have you had a problem like this in the past? If so, when?_____
8. Please list all the diagnostic tests and treatments that have been performed for the problem that we are seeing you for today (please provide when / where / what): _____

_____

REVIEW OF SYSTEMS

*Please circle **Yes** or **No** for each symptom listed below.* ***Do not leave any blanks.***

Constitutional			*Musculoskeletal*		
Recent Weight Changes	Yes	No	Joint Pain/Swelling	Yes	No
Chills or Fever	Yes	No	Joint Stiffness	Yes	No
Fatigue	Yes	No	Limited use of a Joint	Yes	No
Hot or Cold Spells	Yes	No	Bone Deformities	Yes	No
Respiratory			Muscle Cramping/Pain	Yes	No
Morning Cough	Yes	No	Loss of Muscle Strength	Yes	No
Shortness of Breath	Yes	No	*Genitourinary*		
Cardiovascular			Frequent Urination	Yes	No
Heart or Chest Pain	Yes	No	Burning on Urination	Yes	No
Abnormal Heartbeat	Yes	No	Incontinence	Yes	No
Badly Swollen Ankles	Yes	No	*Neurological*		
Calf Cramps	Yes	No	Frequent Headaches	Yes	No
Gastrointestinal			Blackouts	Yes	No
Poor Appetite	Yes	No	Seizures	Yes	No
Nausea/ Vomiting	Yes	No	Tremors	Yes	No
Loss of Bowel	Yes	No	Difficulty Balance	Yes	No
Abdominal Pain	Yes	No	*Psychiatric*		
Constipation/ Diarrhea	Yes	No	Anxiety	Yes	No
			Depression	Yes	

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PATIENT'S MEDICAL HISTORY

Please circle all that apply. NONE OTHER:_____

AIDS/HIV	Atrial Fibrillation	Coronary Artery Disease	Diabetes	GERD	Juvenile Rheumatoid Arthritis	Migraine Headaches	Peptic Ulcer Disease	Scoliosis	Valvular Disease
Alcoholism			Drug Abuse	Gout				Seizure Disorder	
Alzheimer's	BPH					Myocardial Infarction (heart attack)	Psoriasis		
Anemia	Cancer	Crohn's Disease	DVT (blood clot)	Hepatitis	Kidney Disease		PVD	SLE (Lupus)	
Angina	Congestive Heart Failure	Deg. Joint Disease	Fibromyalgia	Hypertension	Liver Disease	Obesity	Renal Disease	Sleep Apnea	
Arthritis				IBD				Stroke	
Asthma	COPD	Depression	Gallbladder Disease		Lyme Disease	Osteoporosis	Rheumatoid Arthritis	Thyroid Disease	

FAMILY HISTORY

Please circle each condition listed below that either your **Mother (M), Father (F),** or **Other (O)** family member have or had.

Stroke	Mother	Father	Other	*Arthritis*	Mother	Father	Other
Heart Trouble	Mother	Father	Other	*Gout*	Mother	Father	Other
High Blood Pressure	Mother	Father	Other	*Mental Illness*	Mother	Father	Other
Diabetes	Mother	Father	Other	*Cancer*	Mother	Father	Other
Bleeding Disorder	Mother	Father	Other	*Alcoholism*	Mother	Father	Other
Anesthesia Problems	Mother	Father	Other				

If other was selected, please describe relationship here: _____

_____

SOCIAL HISTORY

Please circle all that apply.

Smoking or use of tobacco products: Never Former Yes

If yes or former: Years of use_____ Number of packs or products per day _____ Date Last Used _____

Alcohol use: None Socially Rarely Moderately Daily

Recreational Drug Use: None Occasionally Presently Past Problem

Hand Dominance: Right Left Ambidextrous

SURGICAL HISTORY

Please include approximate dates. *No Prior Surgeries*

_____

_____

ALLERGIES

Please fill out the following:

Medication / Other Substance:	Reaction:	Severity of Allergy: *(please circle)*			
_____	_____	Mild	Moderate	Severe	Intolerable
_____	_____	Mild	Moderate	Severe	Intolerable
_____	_____	Mild	Moderate	Severe	Intolerable

CURRENT MEDICATION LIST

Please include all medications prescribed by a physician, any over-the-counter (OTC) medications, any herbal supplements, and vitamins. ***NONE***

_____

_____

PREFERRED PHARMACY NAME AND LOCATION

_____