Orthopedic Initial History Survey

Date:__________________ Chart # _________________ Provider ____________________

Patient Name (Please Print) _______________________ DOB___/___/___ Temp _____ H ___/___ W _____

Age ____ ❒F ❒M Height ___/___ Weight _____ Did you bring x-rays? ❒Y ❒N Labs ❒Y ❒N

Who requested that you visit this office? ❒Doctor (Name)__________________ ❒ Self-Referral ❒Attorney___________

What is the main reason for this visit? (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 ❒Years

Are you right or left handed? ❒Right ❒Left

Did you have an injury? ❒Yes ❒No If so, was it…

At work? ❒Yes ❒No

In a motor vehicle accident? ❒Yes ❒No

Other type of injury?____

Date of Injury?____

Litigation pending? ❒Yes ❒No

Was onset: ❒ Gradual or ❒Sudden 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 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 your sleep? ❒Yes ❒No

What makes your symptoms **worse**? ❒Activity ❒Exercise ❒Work

❒Other____

Which makes you feel better? ❒Rest ❒Heat ❒Ice ❒Elevation

❒Other____

Do you have any of the following? ❒Fever ❒Chills ❒Sweats

Do you have difficulty in controlling your bowels or bladder? ❒Yes ❒No

Check which treatments you have tried for today's problem:

❒Injection ❒Brace ❒Therapy ❒Cane/Crutch ❒Chiropratctor ❒Orthotics ❒Other______________

PREVIOUS INJURIES

1) Have you had prior problems with this same Orthopedic condition in the past? ❒Y ❒N (explain below)

If yes, when?____

What Diagnostic tests have you had for this problem?

❒X-rays ❒Bone Scan ❒Myelogram ❒MRI

❒EMG/NCS ❒Dexa Scan ❒CT Scan ❒Other_________

PAST MEDICAL HISTORY:

2) Do you have any of the following Medical Problems? Please check the ones that apply

AIDS/HIV	❒	Bleeding Problems	❒	COPD	❒	Stroke	❒
Migraines	❒	Emphysema/Asthma	❒	Hepatitis A,B,C	❒	Polio	❒
Anemia	❒	Fibromyalgia	❒	Osteoporosis	❒	Stomach Prob.(Ulcers,Reflux)	❒
Arthtitis	❒	Heart Problems	❒	Nerve Probs	❒	Thyroid Problems	❒
Diabetes	❒	Kidney Problems	❒	Pneumonia	❒	Blood Clots (DVT,PE)	❒
Epilepsy	❒	High Blood Pressure	❒	Psychiatric Disorders	❒	Rheumatoid Arthritis	❒
Gout	❒	Muscle Diseases	❒	Depression/Anxiety	❒	❒Other_____________________	

Cancer ❒ **Type:** ❒Breast ❒Prostate ❒Lung ❒Thyroid ❒Myeloma ❒Other_____________________

PAST SURGICAL HISTORY

3) Have you had any of the following surgeries? Please check the ones that apply and give the date

Arthroscopy	❒Left ❒Right	❒Ankle ❒Knee ❒Shoulder ❒ Wrist	❒___/___
Replacement	❒Left ❒Right	❒Ankle ❒Knee ❒Shoulder ❒Hip ❒Elbow	❒___/___
Fracture Fixation	❒Left ❒Right	❒Ankle ❒Calcaneus ❒Elbow ❒Femur ❒Foot ❒Forearm ❒Shoulder ❒Hip ❒Tibia ❒Wrist	❒___/___

ACL Reconstruction	❒___/___	Cervical Fusion	❒___/___	Lumbar Fusion	❒___/___
Brain Surgery	❒___/___	Hand Surgery	❒___/___	Pacemaker	❒___/___
Breast Surgery	❒___/___	Intramedullary Nail Femur	❒___/___	Splenectomy	❒___/___
Cardiac Stent	❒___/___	Intramedullary Nail Tibia	❒___/___	Thoracic Fusion	❒___/___
Cardiac Surgery	❒___/___	Thoracic Discectomy	❒___/___	_____________	❒___/___
Carpal Tunnel	❒___/___	Lumbar Discectomy	❒___/___	_____________	❒___/___

SOCIAL HISTORY

Do you use tobacco? ❒Y ❒N **Packs per day______** Smokeless varieties______

Alcohol use? ❒Y❒N How often? ❒ Daily___/Week

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

Are you currently working? ❒Y ❒N ❒Retired

Occupation:________________ ❒Student

Employer:___________________________ If not working, how long have you been off work?__________

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

* 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_____________

Blood Clots ❒Y ❒N Arthritis ❒Y ❒N_________ Cancer ❒Y ❒N If yes, Type: ______________________________

REVIEW OF SYSTEMS: Do you currently have any of the following medical symptoms? Please check those that apply.

Chest Pain	❒	Constipation	❒	Abnormal Bleeding	❒	Abnormal Menstrual Cycle	❒
Cough	❒	Cold Hands/Feet	❒	Growth Disturbance	❒	Incontinence of Bowel	❒
Depression	❒	Loss of Appetite	❒	Runny Nose	❒	Incontinence of Urine	❒
Ear Pain	❒	Muscle Weakness	❒	Numbness of Feet	❒	Sleep Disturbance	❒
Fainting	❒	Impotence	❒	Numbness of Hands	❒	Sputum Production	❒
Fever	❒	Balance Problems	❒	Shortness of Breath	❒	Visual Disturbance	❒
Mania	❒	Seizures	❒	Sore Throat	❒	Swelling in the Legs	❒
Skin Rash	❒	Skin Ulcers	❒	Wheezing	❒	Unexplained Weight Loss	❒
Vomiting	❒	Stomach Pain	❒	Weight Gain	❒	Other_________________________	

Are you independent in normal daily activities? Yes/No Has this changed recently? Yes/No

Current Medications:	Dosage		Dosage

Medication Allergies: ❒Y ❒N **If yes, please list:** ____

____

Have you ever had a reaction to anesthesia? ❒Y ❒N

Patient Signature:_______________________ Date__/__/__ Reviewed by MD Date__/__/__

Reviewed by MD________________________ Date__/__/__ Reviewed by MD Date__/__/__