PERSONALIZED ORTHOPEDICS OF THE PALM BEACHES

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: O African American O Asian O Caucasian O Native American/Alaskan O Pacific Islander O Other _
O Unknown O Decline to Answer

Ethnicity: O Hispanic O Non-Hispanic O Unknown O Decline to Answer

Preferred Language: O English O Spanish O Chinese O Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: O Right O Left O Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

O Pain O Numbness/Tingling O Fracture O Stiffness O Annual Follow Up Other: _____

Shoulder	O	Right	O	Left	Pelvis	O	Right	O	Left	Neck	O
Upper Arm	O	Right	O	Left	Hip	O	Right	O	Left	Upper Back	O
Elbow	O	Right	O	Left	Thigh	O	Right	O	Left	Mid Back	O
Forearm	O	Right	O	Left	Knee	O	Right	O	Left	Low Back	O
Wrist	O	Right	O	Left	Lower Leg	O	Right	O	Left	Buttocks	O
Hand	O	Right	O	Left	Ankle	O	Right	O	Left	Tail Bone	O
Thumb	O	Right	O	Left	Foot	O	Right	O	Left		
Index	O	Right	O	Left	Great Toe	O	Right	O	Left		
Middle	O	Right	O	Left	2nd Digit	O	Right	O	Left		
Third	O	Right	O	Left	3rd Digit	O	Right	O	Left		
Little	O	Right	O	Left	4th Digit	O	Right	O	Left		
					5th Digit	O	Right	O	Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

O No Injury O Injury O Injury at Work O Auto Accident
O Sport Injury O Prior Surgery O Surgery Complication

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: O Acute (sudden) O Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? O Yes O No

Attorney Name: _____

Will there be any legal actions with respect to this problem? O Yes O No

3. Have you had a problem like this before? O Yes O No

Describe: _____

_____

4. Have you been seen in an ER for this problem? O Yes O No

Treating ER: (ex. St. Luke's Health) _____ **Date:** (mm/dd/yyyy) _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep?

○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	
Chiropractor	○ Improved	○ Worsened	○ Unchanged	
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	
Home Exercise Program	○ Improved	○ Worsened	○ Unchanged	
Surgery	○ Improved	○ Worsened	○ Unchanged	
Injections	○ Improved	○ Worsened	○ Unchanged	
Bracing	○ Improved	○ Worsened	○ Unchanged	
TENS unit	○ Improved	○ Worsened	○ Unchanged	

Other/Comments: _____

 Patient Name: _____

Select all previous hospitalizations/surgeries: ○ **None**

○ Aneurysm (Brain) Surgery	○ Hysterectomy
○ Aortic Bypass / Vascular Surgery	○ LAP Band / Gastric Bypass Surgery
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
Total Shoulder Replacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ **None for all**

				None	Comments
1) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue	○	_____
2) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss	○	_____
3) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	_____
4) CV	○ Chest Pain	○ Palpitations		○	_____
5) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	_____
6) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	_____
7) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	_____
8) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	_____
9) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness		
10) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	_____
11) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○	_____

Family History

Have any direct relatives had any of the following disorders? ○ **None for all**

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? ○ Current, every day smoker ○ Current, some day smoker ○ Former smoker ○ Never ○ Heavy tobacco smoker ○ Light tobacco smoker

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

Please list work restrictions, if any: _____

Occupation: _____ **Employer:** _____ ○ **Student**

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV / AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy / Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type: _____ Last A1C: _____		○ Stroke / TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____

_____ _____

Signature **Date**