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Date: _____

DOB: _____

Name: _____

Medical History and Information

Age: _____ Circle one: Male Female Occupation (if retired, previous): _____

Present Complaint

Please circle: left right both
 hip knee shoulder elbow ankle foot hand other: _____

Date of onset and length of problem: _____

Associated signs and symptoms (swelling, fever, weakness, etc.): _____

Was the problem caused by an accident or injury? **Yes No**

If yes, what type of incident? _____ Date of injury: _____

Have you ever had surgeries on the above area(s)? **Yes No**

If yes, please describe the most recent surgery:

Type of surgery: _____

Date of surgery: _____ Surgeon: _____

Please list other surgeries on this area prior to the one above: _____

(if applicable, please check one in each group that best describes your present problem)

- | | |
|--|---|
| <p><u>PAIN</u></p> <p><input type="checkbox"/> Not controlled with prescription pain medicine</p> <p><input type="checkbox"/> Controlled only with prescription pain medicine</p> <p><input type="checkbox"/> Bearable with non-prescription pain medicine</p> <p><input type="checkbox"/> Relieved by rest</p> <p><input type="checkbox"/> Occasional but not serious</p> <p><input type="checkbox"/> None</p> | <p><u>STAIRS</u></p> <p><input type="checkbox"/> Cannot climb stairs</p> <p><input type="checkbox"/> 1 to 3 steps with great difficulty</p> <p><input type="checkbox"/> One step at a time with support (cane, banister)</p> <p><input type="checkbox"/> One step at a time without support</p> <p><input type="checkbox"/> Step over step with support</p> <p><input type="checkbox"/> Step over step without support</p> |
|--|---|

Does pain wake you at night? **Yes No**

Describe the pain (i.e., throbbing, pounding, burning, dull, etc.) _____

What alleviates or worsens the pain? _____

- | | |
|--|---|
| <p><u>WALKING</u></p> <p><input type="checkbox"/> Bedridden</p> <p><input type="checkbox"/> Use wheelchair, can transfer by self</p> <p><input type="checkbox"/> Use crutches or walker around the house</p> <p><input type="checkbox"/> 1 to 2 blocks with or without cane or crutch</p> <p><input type="checkbox"/> 3 to 5 blocks with or without cane or crutch</p> <p><input type="checkbox"/> Unlimited activity</p> <p>Length of time walking aid needed: _____</p> | <p><u>CHAIRS</u></p> <p><input type="checkbox"/> Cannot get in or out of chair by self</p> <p><input type="checkbox"/> Can get in and out of chair with great difficulty and help from another person</p> <p><input type="checkbox"/> Can get in and out of chair by self with chair arm support</p> <p><input type="checkbox"/> Can get in and out of chair with minimal arm support</p> <p><input type="checkbox"/> Can get in and out of chair with minimal arm support</p> <p><input type="checkbox"/> Can get in and out of chair with no problem</p> |
|--|---|

Can you cut your toenails? (circle one) **Yes No With great difficulty**

Past Medical History

Have you been treated for any of the following illnesses? (please check)

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease/heart attack | <input type="checkbox"/> Immunodeficiency | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy |

Please comment on any illness checked: _____

Past Surgical History

Please list other previous surgeries, complications, and year of surgery:

List all current medications you take on a regular schedule (include non-prescription medications):

	<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Are you allergic to any medication or food? **Yes** **No**

If Yes, please list: _____

Family History

Please list all diseases that run in your family (for example: diabetes, arthritis, bleeding disorders, or anesthetic problems such as malignant hyperthermia). _____

Mother is (circle one) alive deceased. If deceased, died of _____ Age: _____
 Father is (circle one) alive deceased. If deceased, died of _____ Age: _____

Social History

Marital Status (circle one): Married Single Divorced Widowed
 Do you smoke or use tobacco? **Yes** **No** If yes, how much each day? _____
 Do you drink alcohol? **Yes** **No** If yes, how much? _____
 Currently Employed? **Yes** **No**
 Disabled? **Yes** **No**

Review of Systems (Check all that apply and explain).

<u>SYSTEM</u>	<u>EXAMPLES</u>	<u>LIST OTHER PROBLEMS</u>
<input type="checkbox"/> General	fever, weight loss, fatigue, weakness	_____
<input type="checkbox"/> Eyes	glasses, visual disturbances, dryness	_____
<input type="checkbox"/> Ear, Nose, Throat	vertigo, sinusitis, hoarseness	_____
<input type="checkbox"/> Heart	chest pain, palpitations, murmurs	_____
<input type="checkbox"/> Lungs	short of breath, asthma, cough, wheezing	_____
<input type="checkbox"/> Circulation	clots, edema, varicosities, claudication	_____
<input type="checkbox"/> Digestive Tract	diarrhea, constipation, ulcers, pain	_____
<input type="checkbox"/> Kidney, Urinary	stones, burning, urgency, bleeding	_____
<input type="checkbox"/> Skin, Breast	rashes, lumps, itching, hair/nail changes	_____
<input type="checkbox"/> Endocrine	excess thirst, decreased energy	_____
<input type="checkbox"/> Neurologic	stroke, seizures, tremor, weakness	_____
<input type="checkbox"/> Psychiatric	depression, sleep disturbances, anxiety	_____
<input type="checkbox"/> Blood, Lymph	easy bruising, blood disorders	_____
<input type="checkbox"/> Musculoskeletal	fracture, arthritis, loss of motion, cramps	_____

Patient or Guardian Signature

Date

Reviewed by (Physician Signature)

Date