orthopedic ONE

Medical History

Patient Last Name _____ First _____ Date of Birth _____

PAST MEDICAL HISTORY

Please check the box to indicate if you have a history of any of the following medical problems. Select all that apply.

- ☐ AFIB
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer(s)*
- ☐ Cardiac Stent
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Dementia/Alzheimer's
- ☐ Developmental Delay
- ☐ Diabetes – Type I/II
- ☐ DVT
- ☐ Enlarged Prostate
- ☐ Epilepsy/Seizure Disorder
- ☐ Fibromyalgia
- ☐ Heart Disease/Heart Attack
- ☐ Hepatitis B
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Issues
- ☐ MRSA Infection
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker/Defibrillator
- ☐ PE/Pulmonary Embolism
- ☐ Reflux Disease/GERD
- ☐ Rheumatoid Arthritis
- ☐ Rheumatologic Disorder
- ☐ Scoliosis
- ☐ Sickle Cell Anemia
- ☐ Sleep Apnea
- ☐ Stroke/TIA
- ☐ Thyroid Disease
- ☐ Other: _____ _____
- ☐ I have no past medical problems

*Type of Cancer _____

Are you currently being treated?
☐ No
☐ Yes

If yes, please describe treatment _____ _____

MEDICAL CARE HISTORY

☐ No prior surgeries

List prior surgeries & dates if known:

_____
_____
_____
_____

Have you ever experienced anesthesia complications?
☐ No ☐ Yes, please explain below

_____

Have you seen a cardiologist? ☐ No ☐ Yes

If yes, name: _____

Have you seen a pain management specialist? ☐ No ☐ Yes

If yes, name: _____

FAMILY HISTORY

Please check the box to indicate if your **Mother and/or Father** have a history of any of the following medical conditions. Select all that apply.

- ☐ Bleeding Disorder
- ☐ DVT/PE
- ☐ Malignant hyperthermia
- ☐ Rheumatologic disorder
- ☐ No Family History
- ☐ Unknown/Adopted

SOCIAL HISTORY

Current Marital/Legal Status:
- ☐ Single
- ☐ Married
- ☐ Legally Separated
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Widowed

LIVING ARRANGEMENTS
- ☐ Alone
- ☐ Caregiver for others
- ☐ Family/Roommate
- ☐ Dependent on caregiver for daily activities
- ☐ Retirement Community
- ☐ Skilled Nursing Facility
- ☐ Assisted Living

FALL HISTORY

Have you fallen in the past 12 months?
☐ Yes
☐ No

If yes, have you fallen more than one time?
☐ Yes
☐ No

PATIENT INFORMATION

Hand Dominance. Which hand do you write with? ☐ Right ☐ Left

Tobacco/Nicotine Use. ☐ Non-user ☐ Current user ☐ Former user. Year Quit _____
If a current or former user, check the type used:
☐ Cigarettes ☐ E-cigarettes ☐ Vape ☐ Cigar/pipe ☐ Smokeless ☐ Nicotine gels/dissolvable

Alcohol Use. Please indicate which best describes your habits
☐ Current Alcohol Use ☐ Occasional Alcohol Use ☐ Rare Alcohol Use ☐ Never Used Alcohol

Drug Use.
☐ No Illicit Drug Use ☐ Recreational Drug Use Type used, if applicable: _____

orthopedic ONE

Reason for Visit

Patient Last Name _____ First _____ Date of Birth _____

MEDICATIONS List all current medications – including prescription, non-prescription, vitamins, and supplements.

☐ I have reviewed my medications and there are no changes since my last appointment. Patient initials _____

Medication	Dose/How Taken/How Often	Medication	Dose/How Taken/How Often
1		6	
2		7	
3		8	
4		9	
5		10	

ALLERGY & REACTIONS List all allergies including metal and latex.

Name of Allergy	Reaction	Name of Allergy	Reaction
1		3	
2		4	

LOCATION OF CURRENT PROBLEM / REASON FOR THE VISIT Please indicate by checking the most accurate reason

Upper Extremities

Upper Arm/Shoulder/Clavicle
☐ Right ☐ Left ☐ Both

Elbow/Forearm
☐ Right ☐ Left ☐ Both

Wrist/Hand/Fingers
☐ Right ☐ Left ☐ Both

Lower Extremities

Hip/Thigh
☐ Right ☐ Left ☐ Both

Knee/Lower Leg
☐ Right ☐ Left ☐ Both

Ankle/Foot/Toes
☐ Right ☐ Left ☐ Both

Spine

☐ Neck (Cervical)
☐ Middle (Thoracic)
☐ Lower (Lumbar)

Chief Complaint – Please select all that apply. ☐ Pain ☐ Tingling/Numbness ☐ Weakness ☐ Other: _____

Pain Severity – Without taking pain medication and while performing normal daily activities.

None — Moderate — Severe

0 1 2 3 4 5 6 7 8 9 10

Approximately how long has this problem/concern been on going? _____

Is this associated with an injury? ☐ No ☐ Yes If yes, how were you injured? _____

Date of injury:_____ Is your injury work related? ☐ No ☐ Yes

If work related: BWC/Managed Care Organization:_____ Claim Number: _____

PREVIOUS TREATMENTS FOR THIS PROBLEM

☐ Acupuncture
☐ Bracing/Splinting
☐ Chiropractic Care
☐ Gel Injection
☐ Massage
☐ Medications/Supplements
☐ Therapy Physical/ Occupational/Hand
☐ Podiatry
☐ Steroid Injection
☐ Surgery*
☐ Other:_____

*Type of Surgery_____

PREVIOUS TESTING FOR THIS PROBLEM

☐ CT (CAT) Date:_____ Location_____
☐ EMG Date:_____ Location_____
☐ MRI Date:_____ Location_____
☐ X-Ray Date:_____ Location_____
☐ Other Date:_____ Location_____
Other:_____
☐ No Previous Testing

CURRENT WORK STATUS

Which most accurately describes your current work status?

Working:
☐ Full Time
☐ Part Time

Not Currently Working:
☐ Disabled ☐ Retired
☐ Student ☐ Unemployed

Employer_____

Occupation_____

Are you able to perform your job duties?
☐ Yes, all regular duties ☐ No, unable to perform any duties
☐ Yes, only light duties ☐ No, unable & currently on disability