ACADEMY ORTHOPEDICS

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: ____ **Date of Birth:** ___________________
Age: _________ **Sex:** ○ M ○ F **Height:** __________ **Weight:** ___________
Race: ○ Caucasian ○ African American ○ Hispanic ○ Asian ○ Other
Ethnicity: _________________ **Preferred Language:** ________________________
Pharmacy: _________________ **Pharmacy Phone#:** ________________________
How were you referred to our practice: ○ Google ○ Yahoo ○ YellowPages.com ○ Friend/Family ○ Insurance Company
○ Zoc Doc ○ I am a previous patient ○ My doctor: Name of referring doctor _________________ ○ Other

Part of the body scheduled to be seen for today:

○ Neck:		**I experience:**	○ Pain into arm	○ Tingling above elbow	○ Tingling below elbow
○ Shoulder:	○ Right ○ Left	**I experience:**	○ Pain at neck ○ Pain down arm	○ Pain with abduction (when I move or raise my arm away from my body) ○ Pain with adduction (when I lower my arm toward my body) ○ Pain above elbow	○ Pain below elbow
○ Elbow:	○ Right ○ Left	**I experience:**	○ Pain into hand	○ Pain into forearm	○ Numbness ○ Swelling ○ Tingling ○ Weakness
○ Hand/ Wrist:	○ Right ○ Left	**I experience:**	○ Numbness	○ Tingling ○ Weakness	
○ Knee:	○ Right ○ Left	**I experience:**	○ My symptoms are below the knee ○ My symptoms are above the knee		○ Swelling ○ Giving way ○ Locking
○ Foot/ Ankle/Leg:	○ Right ○ Left	**I experience:**	○ Swelling	○ Numbness ○ Tingling	
○ Hip/Back:	○ Right ○ Left	**I experience:**	○ Numbness ○ Tingling	○ Pain into left leg ○ Pain into right leg	○ Pain when cough and/or sneeze

Select only ONE option which best describes how your problem started. Answer the questions related to the selected option.

○ **NO INJURY** Was the onset ○ Gradual ○ Sudden Onset Date: ______________________
OR
○ **INJURY** ○ Accident ○ Sport Date: ______________________
OR
○ **INJURY AT WORK** Date: ______________________ ○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive
OR
○ **AUTO ACCIDENT** Date: ______________________

Were you seen in the E.R. for this problem? ○ N ○ Y Which E.R.? _________________________________

What test/scans have you had for this problem? ○ None ○ X-rays ○ MRI ○ CAT Scan ○ Nerve Test (EMG/NCV)

Does the pain wake you from your sleep? ○ N ○ Y

Have you ever had a Bone Density Scan? ○ No ○ Yes When? ________________________________
(All female patients or male patient over the age of 75 only)

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Patient Name: ____

PAST MEDICAL HISTORY

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

○ Aneurysm (Brain) Surgery	○ Carpal Tunnel Surgery	○ Gastric Bypass/LAP Band Surgery	
○ Ankle Surgery	○ Cataract (Eye) Surgery	○ Hysterectomy	○ Sinus Surgery
○ Aortic Bypass / Vascular Surgery	○ Cholecystectomy (Gallbladder)	○ Knee Surgery	○ Stents
○ Appendectomy	○ Elbow Surgery	○ Neck Surgery	○ Total Joint Replacement
○ Back Surgery	○ Foot Surgery	○ Open Heart Surgery	○ Wrist Surgery
○ Carotid Endarterectomy	○ Fracture Repair Surgery	○ Shoulder Surgery	

Are you taking, or have you ever taken, blood thinners? ○ N ○ Y If Yes, which one? ___________________

Select all medications you are taking on a regular basis: ○ **None**

○ Abilify	○ Combivent	○ Flovent HFA	○ Lovaza	○ Plavis	○ VESIcare
○ Acetaminophen/hydrocodone		○ Geodon	○ Lunesta	○ Pradaxa	○ Viagra
○ Aciphex	○ Coumadin	○ Humalog	○ Lyrica	○ Procrit	○ Vytorin
○ Actos	○ Crestor	○ Humira	○ Methylphenidate	○ Provigil	○ Vyvanse
○ Adderall XR	○ Cymbalta	○ Janumet	○ Metoprolol	○ Remicade	○ Zetia
○ Advair Diskus	○ Diovan	○ Januvia	○ Namenda	○ Seroquel	○ Zyprexa
○ Amphetamine/dextroamphetamine		○ Lantus	○ Nasonex	○ Seroquel XR	○ Zyvox
○ Atorvastatin	○ Diovan HCT	○ Lantus Solostar	○ Neupogen	○ Singulair	
○ Avastin	○ Enbrel	○ Lexapro	○ Nexium	○ Spiriva	
○ Benicar	○ Enoxaparin	○ Lidoderm	○ Niaspan	○ Symbicort	
○ Celebrex	○ Epogen	○ Lipitor	○ Novolog FlexPen	○ TriCor	
○ Cialis	○ Fentanyl	○ Lisinopril	○ OxyContin	○ Ventolin HFA	

Are you allergic to any medications? ○ N ○ Y If Yes, please list below:

Medication	**Reaction**
______________________________________ ______________________________________ ______________________________________	______________________________________ ______________________________________ ______________________________________
Latex allergy? ○ N ○ Y	

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

○ Abnormal Blood Pressure	○ Continuous Seizures	○ Lung Disease
○ Arthritis Type: ________________	○ Diabetes Type: ___________	○ Pacemaker
○ Asthma	○ Emphysema	○ Problems with Wounds Healing
○ Birth Defects	○ Epilepsy	○ Psychiatric Care
○ Blood Clots	○ Excessive or Prolonged Bleeding	○ Reaction to Anesthesia Type: _______________
○ Bone or Joint Infections	○ Fractures / Joint Dislocations	○ Rheumatic Fever
○ Cancer Type: ________________	○ Gout	○ Sleep Apnea
○ Chemical Dependency	○ Heart Disease / Defect	○ Stomach Ulcers
○ Chemotherapy / Radiation	○ Hepatitis	○ Stroke
○ Circulatory Problems	○ HIV / AIDS	○ Tuberculosis
Claustrophobic? ○ N ○ Y	Use a C PAP? ○ N ○ Y	Are you Pregnant *(females only)*? ○ N ○ Y

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Patient Name: ____

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?						
FATHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis

REVIEW OF SYSTEMS

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS IN THE PAST 6 MONTHS?					NONE	COMMENTS
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	______________
2) ENDO	○ Thyroid Disease	○ Heat or Cold Intolerance			○	______________
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	______________
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	______________
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	______________
6) CV	○ Chest Pain	○ Palpitations			○	______________
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	______________
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	______________
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	______________
10) NEU	○ Headaches	○ Dizziness	○ Seizures	○ Numbness	○	______________
11) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder		○	______________
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	______________

SOCIAL HISTORY

Do you use tobacco? ○ N ○ Y If Yes, packs per day ______ ○ Quit **Informed of Smoking Risk?** ○ N ○ Y

Alcohol use? ○ N ○ Y ○ Quit

Marital History: ○ Married ○ Single ○ Divorced ○ Widowed

Are you currently working? ○ N ○ Y ○ Retired ○ Disabled If no, when did you last work? _______________

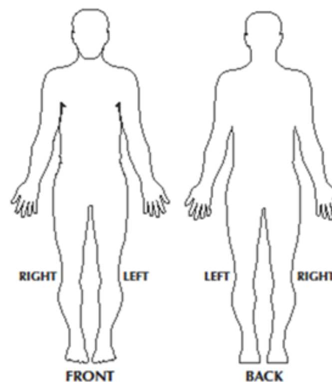
Are you currently on any work restrictions? ○ N ○ Y If Yes, what are they? _________________________

Occupation: _________________________ **Employer:** ______________________ ○ **Student**

PAIN DRAWING

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



____ ____________

Signature **Date**

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