

Scotland Orthopedics New Patient History

Patient Name (print) _____ Birthdate _____ Today's Date: _____

Age _____ F M Dominant hand R L Height _____ Weight _____

Who requested that you visit this office? Doctor (Name) _____ Self-referral Attorney _____

1. *(Chief Complaint) Main reason for visit? Pain Numbness Weakness Other _____

2. *Location) What body part is involved? (Check below)

| | | | | | | |
|--|---|--|---|---|--|---|
| Neck <input type="checkbox"/> and <input type="checkbox"/> R arm Radiates to <input type="checkbox"/> L arm | Shoulder <input type="checkbox"/> R <input type="checkbox"/> L | Elbow <input type="checkbox"/> R <input type="checkbox"/> L | Hand <input type="checkbox"/> R <input type="checkbox"/> L | Pelvis <input type="checkbox"/> R <input type="checkbox"/> L | Knee <input type="checkbox"/> R <input type="checkbox"/> L | Foot <input type="checkbox"/> R <input type="checkbox"/> L |
| Back <input type="checkbox"/> and <input type="checkbox"/> R arm Radiates to <input type="checkbox"/> L arm | Arm <input type="checkbox"/> R <input type="checkbox"/> L | Wrist <input type="checkbox"/> R <input type="checkbox"/> L | Finger <input type="checkbox"/> R <input type="checkbox"/> L | Hip <input type="checkbox"/> R <input type="checkbox"/> L | Ankle <input type="checkbox"/> R <input type="checkbox"/> L | Toe <input type="checkbox"/> R <input type="checkbox"/> L |

3. *(Duration) How long has this problem been present? _____ Days _____ Weeks _____ Months _____ Years

4. *Check the ONE box below that best describes how your problem started. Then use the space to the right to answer the ONE question below the box you check. Use as much space as needed.

NO INJURY (onset was: Gradual or Sudden)

ANSWER:

COMMENTS:

Why do you think it started?

INJURY (from Accident or Sport NOT work or Auto)

Date _____, Where and how did it happen?

What sport _____ School _____

INJURY AT WORK (Date _____)

From a lift twist bend pull reach

Work RELATED (BUT NO INJURY)

Date _____, How did you cause this problem?

AUTO ACCIDENT (Date _____) How was car hit?

Please check the box in each category that best describes your problem.

5. *Severity of pain? Mild Moderate Severe Extremely severe _____

6. *Quality of pain? Sharp Dull Stabbing Throbbing Aching Burning _____

7. Timing of pain? Constant Comes and goes (intermittent). Does pain wake you from sleep? Yes No

8. Do you have? Swelling Bruise Numbness Tingling Weakness Loss of bowel or bladder control

9. Since my problem started, it is: Getting better Getting worse Unchanged _____

10. What makes your symptoms worse? Standing Walking Lifting Exercise Twisting Lying in bed
 Bending Standing Kneeling Sitting Coughing Sneezing

11. What makes it better? Rest Heat Ice Elevation Other _____

12. What medications have you taken for this problem? _____

13. Which treatment have you tried? Injection Brace Therapy Cane/crutch

14. Were you seen in an Emergency Room for this problem? N Y Which ER and date? _____

15. What tests have you had? X-rays MRI CAT scan Bone scan Nerve test (EMG/NCV)

16. Have you already had surgery for this problem? N Y Surgeons Name _____ Date _____

PAST MEDICAL HISTORY (answering these questions helps the doctor effectively treat your current orthopedic problem)

1. Do you take any prescription or non-prescription MEDICATIONS? No Yes (list below)

| Medication | Dose | Medication | Dose |
|------------|------|------------|------|
| | | | |
| | | | |
| | | | |

Are you ALLERGIC to any medications? No Yes, List _____

List other products that you are Allergic to (e.g. eggs, latex, iodine, etc.) _____

Have you ever had SURGERY? No Yes (Please List details below)

| Surgery | Date | Surgery | Date |
|---------|------|---------|------|
| | | | |
| | | | |

Did you have any adverse reactions to anesthesia? No Yes (please describe _____)

Do you have any MEDICAL PROBLEMS? No Yes (please circle below or list)

| | | | | |
|--------------|---------------------|-----------------|--------------|----------------------|
| Diabetes | High blood pressure | Heart problems | Blood clots | Asthma |
| Bronchitis | Emphysema | Kidney problems | Hepatitis | Thyroid disease |
| Ulcers | Seizures | Stroke | Tuberculosis | Rheumatoid arthritis |
| Cancer _____ | Other _____ | | | |

REVIEW OF SYSTEMS

1. Have you ever had a prior problem with the same Orthopedic condition you are here for today? N Y
Do you have OTHER JOINTS with morning stiffness, swelling, or pain?
(Please check any that apply to you or mark NONE)
2. Heartburn Nausea Vomiting Blood in stool Stomach pain with anti-inflammatory pills.
3. Excessive thirst Heat or cold intolerance
4. Weight loss Fever Loss of appetite
5. Blurred vision Double vision Trouble swallowing
6. Hearing loss Hoarseness
7. Chest pain Palpitations
8. Chronic cough Shortness of breath
9. Painful urination Blood in Urine
10. Rash Skin ulcers Lumps Psoriasis
11. Headaches Dizziness
12. Depression Drug/Alcohol addiction Sleep disorder
13. Easy bleeding Easy bruising Anemia

FAMILY HISTORY:

Has any direct relative had any of the following? No Yes (please mark all that apply)
Same Orthopedic condition you are being see for today. Rheumatoid arthritis Diabetes
High blood pressure Heart disease Reaction to anesthesia

SOCIAL HISTORY

Do you use tobacco? N Y Packs per day _____ Alcohol use? N Y How often? Daily Other _____
Marital history: M S D W
Occupation: Student Employer _____
Are you currently working? Yes No If NO, how long have you been off work? _____

Patient Signature _____ Date _____

For Office Use Only

Reviewed by MD _____ Date _____