PERSONALIZED ORTHOPEDICS OF THE PALM BEACHES

NEW PATIENT MEDICAL HISTORY FORM

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

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

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

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

Preferred Pharmacy: _____

Date of your appt.: _____ Doctor your appt. is with: _____

Chief Complaint

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

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

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

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

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

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

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

Onset Date: (mm/dd/yyyy) _____

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

Attorney Name: _____

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

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

Describe: _____

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

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

 Patient Name: _____

History of Present Illness (continued)

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

☐ 0 ☐ 1 ☐ ☐ 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	☐	_____

 Patient Name: _____

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 any allergies: ☐ Yes, if so list below ☐ No

Please list current Medications and strength below

_____
_____
_____
_____
_____

Do you have a history of:

☐ Aneurysm	☐ Emphysema	☐ Kidney Disease
☐ Angina	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis	☐ Heart Attack	☐ MRSA
☐ Asthma	☐ Hepatitis	☐ Pacemaker
☐ Bone Infection	☐ HIV/AIDS	☐ Blood Clots
☐ Cancer	☐ High Cholesterol	☐ Embolism
☐ COPD	☐ Hypertension	☐ Seizures
☐ Diabetes	☐ Hyperthyroidism	☐ Stroke

Once completed, please print and bring to your appointment. Thank you!