TENNESSEE VALLEY
BONE and JOINT
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Date:___/____/2017

ORTHOPEDIC PATIENT HISTORY

Name:________________________________ Date of Birth: ________________ Age:____ Referring Physician:_______

Chief Complaint: **What is your main reason for being seen today? Is the area of concern on the right, left, or both sides of your body? ____**

____

Is this complaint due to an injury? Yes No Date of injury? ____/____/____ What state did the injury occur in?_______

Listed below are possible ways of describing your typical pain. Please check all of the descriptions that apply to your primary pain.

Throbbing Shooting Stabbing Sharp Cramping Aching Burning

How often do you experience your pain? Constant Comes and goes Good days and bad days

Place an **X** on the line below to indicate how severe your pain is:

No Pain |0 |1 |2 |3 |4 |5 |6 |7 |8 |9 |10 Worst Pain Imaginable

Past Medical History: **Do you, or have you had any of the following medical problems?**

Asthma	COPD	Depression	Heart Disease	HIV/AIDS	Migraines
Cancer	Diabetes	Congestive Heart Failure	GI Bleed	Arthritis	Gastric Reflux
Hepatitis	Stroke	High Blood Pressure	High Cholesterol	Heart Attack	Liver disease
Fibromyalgia	Seizure	Kidney Problems/failure	Thyroid Disease	Blood Clots	Glaucoma

Any medical problems not listed: ____

Past Surgical History: **Please list any surgeries you have had: ________________________________**

____

Do you have any metal clips, plates, or pins in your body? No Yes Explain: ____________________

Are you claustrophobic or do you have difficulty with enclosed spaces? ____________________________

Medications: **Please list all medications you are currently taking:______________________________**

____

Allergies: **Do you have any drug allergies? No Please list: ________________________________**

Do you receive pain medication from any other provider? Yes No If YES then who:________________

Social History: **Do you engage in the following:** Smoke___ Alcohol____ Use drugs

Marital Status: Single Married Separated Divorced Widowed

Employment: Homemaker Part-time Full-time Unemployed

Education: High School Some College College Grad. Post-Graduate

Occupation: ____________________________

Family History: **Has your father, mother, or sibling had any of the following? (Please check all that apply)**

____ Accidental Death _____Adopted ____Alzheimer Disease _____ Cancer ____ Diabetes ____ Hypertension

____ Heart Attack ____ Kidney Disease ____ Liver Disease ____ Lung Problems _____ Unaware of Medical History

Father Living Deceased Mother Living Deceased

Patient Signature: ____________________________________ Date: ____________________

REVIEW OF SYSTEMS – TO BE FILLED OUT BY PATIENT

Cardiovascular:
- Stroke
- Circulatory Problems
- Heart Attack
- High Blood Pressure
- Chest Pain
- Pacemaker

Respiratory:
- Difficulty Breathing
- Asthma/wheezing
- Cough
- Pulmonary Emboli

Gastrointestinal:
- Stomach Ulcers
- Active Healed
- GERD/Acid Reflux
- Recent change in Bowel Habits

Bleeding Profile:
- Anemia
- Blood Disorders
- Liver Disease
- Family History of Liver Disease

Genitourinary:
- Difficulty Voiding
- Painful Urination
- Blood in Urine
- Frequency

Neuro-Muscular:
- Joint Pain
- Treated for Arthritis
- Muscle Weakness

Endocrine:
- Thirst Change
- Appetite Change
- Diabetes
- Chronic Steroid Use

Allergy:
- Seafood
- X-ray dye
- Seasonal Allergies
- Other ____________

Eyes, Ears, Nose & Throat:
- Glaucoma
- Blurred Vision
- Loss of Vision
- Glasses Contacts
- Ringing in Ears
- Hearing Loss
- Difficulty Swallowing
- Sinus / Nose Bleeds

Constitutional:
- Fever/chills
- Dizziness
- Hot Flashes
- Recent Illness
- Weight Change

TO BE FILLED OUT BY THE PROVIDER

VITAL SIGNS

Temp: _______ **Blood Pressure:** ___________ **Heart Rate:** _______ **Height:** ______ **Weight:** __________

OFFICE NOTES

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

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______________________________ ______________________________

Provider Signature: ____ **Date:** ________________________

Revised: 11/05/09