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## Appalachian Orthopedic Center

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### Medical History and Screening Form

Patient Name:	Occupation:	Date
Referring Physician:	Family Doc:	Date of Birth:
Age:	<input type="checkbox"/> Left Handed <input type="checkbox"/> Right Handed	Height:      Weight:

#### History of Present Illness

Reason for visit?	Was this the result of a work or auto injury? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date of injury: _____
How and When did the problem start?	How did you hear about our practice?

#### Evaluation of Pain / Discomfort

What activities are you unable to do because of the pain?													
Does the pain keep you awake at night? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details?												
What makes it feel better?													
What makes it feel worse?													
Pain Scale (circle one number)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #cccccc; width: 15%; text-align: center;">Mild</td> <td style="background-color: #cccccc; width: 15%; text-align: center;">Moderate</td> <td style="background-color: #cccccc; width: 15%; text-align: center;">Severe</td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> <tr> <td style="text-align: center;">No Pain</td> <td style="text-align: center;">1   2   3</td> <td style="text-align: center;">4   5   6   7   8</td> <td style="text-align: center;">9</td> <td style="text-align: center;">10</td> <td style="text-align: center;">Severe Pain</td> </tr> </table>	Mild	Moderate	Severe				No Pain	1   2   3	4   5   6   7   8	9	10	Severe Pain
Mild	Moderate	Severe											
No Pain	1   2   3	4   5   6   7   8	9	10	Severe Pain								

#### Previous Treatment for this problem

Which other Doctors have you seen for this problem?
What medications have you tried?
Any Physical Therapy?
Other treatments?
Is this being covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a lawsuit or litigation pending in regard to your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last date worked?
Current work restrictions?

#### Past Medical History (please check all that apply)

<input type="checkbox"/> Diabetes <input type="checkbox"/> Blood Clots <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid (Hyper or Hypo) <input type="checkbox"/> Parathyroid <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> AIDS / HIV <input type="checkbox"/> Current Pregnancy	<input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Gastrointestinal Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Prostate <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Vascular Disease (circulation) <input type="checkbox"/> Bladder Disease <input type="checkbox"/> Skin Disorder <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> Other (describe) _____ _____
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**ANY** current infections, open sores, or open wounds?

Patient Name:

Prior Surgeries (all prior surgery and approximate dates)

Blank lines for recording prior surgeries.

Prior Fractures (all prior fractures and approximate dates)

Blank lines for recording prior fractures.

Family History

- Checkboxes for Bleeding Disorder, Malignant Hyperthermia, Osteoporosis, Cancer, Musculoskeletal Disease, Diabetes, Heart Disease, and Other.

Social History

- Checkboxes for Married, Single, Divorced, Widow/Widower, Separated.

Residence

- Checkboxes for Alone, With Family, With Friends, Nursing Home, Retirement Home, Other.

Name of Assisted living facility:

User of:

- Checkboxes for Tobacco, Alcohol, and Illicit/Illegal Drug use, including frequency and quantity.

Review of Symptoms (Please mark all that apply)

Grid of symptom categories: Constitutional, Head/Eye/Ears/Nose/Throat, Gastrointestinal, Skin/Integumentary, Respiratory, Genitourinary, Musculoskeletal, Cardiovascular, Neurological, Psychiatric.

I consent to treatment by Appalachian Orthopedic Center. I grant permission to the physicians and employees to render routine medical care that includes, but is not limited to, diagnostic procedures and medical treatment, administration of approved drugs and nursing care, as well as other medical services provided as part of my medical treatment. I understand that no guarantee or assurance has been made as to the results that may be obtained.

\_\_\_\_\_  
Patient/Guardian Signature/Relationship Date

History Reviewed By:

\_\_\_\_\_  
Nurse Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature