

APPALACHIAN ORTHOPEDIC CENTER

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MEDICAL HISTORY SCREENING FORM

Patient Name: Date of Birth: Age: Today's Date:

Referring Doctor: Family Doctor:

Height: Weight:

HISTORY OF PRESENT ILLNESS:

Reason for visit?

How and When did the problem start?

EVALUATION OF PAIN/DISCOMFORT:

What activities are you unable to do because of the pain?

Does the pain keep you awake at night? No Yes If yes, please give details.

What makes it feel better?

What makes it feel worse?

Pain scale (circle one number) No Pain 1 2(Mild) 3 4 5 6 7 8(Moderate) 9 10 Severe pain (Severe)

PREVIOUS TREATMENT FOR THIS PROBLEM:

Which other doctors have you seen for this problem?

What medications have you used?

Any Physical Therapy? No Yes Other treatments?

Use of assistive devices for this problem? Cane Crutches Splints Braces Walker Wheelchair NONE

Is this being covered by Workmen's Compensation? No Yes Date of Injury:

Is this being covered by Auto? No Yes Date of Injury:

Is there a lawsuit or litigation pending in regard to your injury? No Yes

HISTORY REVIEWED BY:

Nurse Signature

Date

Physician Signature

PATIENT NAME: _____

MARITAL STATUS (SOCIAL HISTORY):

- Married Divorced Separated Single Widow/Widower

LIVES WITH: (SOCIAL HISTORY):

- Alone Family Friends Nursing Home Partner Retirement Home Other: _____

WORK STATUS (SOCIAL HISTORY):

Occupation: _____ Last date worked? _____ or N/A

- Not currently working Currently working Disabled Retired Unemployed Work w/ restrictions

Current work restrictions? No Yes If yes, details please. _____

- Left-handed Right-handed Ambidextrous

PERSONAL HABITS:

Cigarettes: No Occasionally Yes pks/day ____ **or** cig/day ____ **Pipe:** No Occasionally Yes # cigars/day ____

Illegal Drug use: No Occasionally Yes If yes, drug name _____

Chew: No Occasionally Yes How many times a day? ____ **Alcohol:** No Occasionally Yes If yes, how much? ____

PAST MEDICAL HISTORY: (Please check all that apply. If you do not have anything to mark or add please select NONE)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> HIV | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Blood Clots (DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer If so, where? _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Multiple Sclerosis (MS) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Current Pregnancy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hodgkin's Disease | <input type="checkbox"/> Osteoporosis | (circulation) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parathyroidism | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Other: _____ |

ANY current infections, open sores or open wounds? No Yes If so, where? _____

PRIOR SURGERIES (Please mark all that apply. If there are no prior surgeries, please select NONE)

- | | | |
|--|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> D&C (Dilation & Curettage) | <input type="checkbox"/> Pacemaker Insertion |
| <input type="checkbox"/> Arthroscopy: If so, what body part? _____ | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Rotator Cuff Repair |
| <input type="checkbox"/> Breast Lumpectomy | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Shoulder Replacement |
| <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Stent Placement |
| <input type="checkbox"/> Cataract Removal | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Tonsillectomy & Adenoidectomy |
| <input type="checkbox"/> Cholecystectomy (gallbladder) | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> NONE |
| | | <input type="checkbox"/> Other: _____ |

PATIENT NAME: _____

PRIOR FRACTURES (Please write down what fractures you have had in the past. If there are NOT any fractures, please select NONE.)

NONE

FAMILY HISTORY (Please mark all that apply. If you have nothing to select or add, please select NONE.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Cancer: If so, what body part _____ | <input type="checkbox"/> Musculoskeletal Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: _____ |

REVIEW OF SYSTEMS (Please mark all that apply. Mark NONE under EACH section if no symptoms are selected):

<p><u>Constitutional:</u></p> <p><input type="checkbox"/> Fever <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Fatigue <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Sweats</p>	<p><u>Ears, Nose, Mouth & Throat (ENMT):</u></p> <p><input type="checkbox"/> Bloody Nose <input type="checkbox"/> Polyps</p> <p><input type="checkbox"/> Frequent Colds <input type="checkbox"/> Sinus Pain</p> <p><input type="checkbox"/> Mouth Breathing <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Cardiovascular (CV):</u></p> <p><input type="checkbox"/> Coronary Artery Disease (CAD)</p> <p><input type="checkbox"/> Congestive Heart Failure (CHF)</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>
<p><u>Respiratory:</u></p> <p><input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Pneumonia <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Sleep apnea <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Gastrointestinal (GI):</u></p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Bloody stools</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> GERD (gastroesophageal reflux disease)</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> IBS (irritable bowel syndrome)</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Ulcer disease</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Hematologic/Lymphatic:</u></p> <p><input type="checkbox"/> Bleeding/clotting disorder</p> <p><input type="checkbox"/> Easy Bleeding</p> <p><input type="checkbox"/> Easy Bruising</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>
<p><u>Musculoskeletal:</u></p> <p><input type="checkbox"/> Ambulatory dysfunction</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Balance, poor</p> <p><input type="checkbox"/> Deformities</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Herniated disc</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint stiffness</p> <p><input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Rheumatoid arthritis</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Genitourinary (GU):</u></p> <p><input type="checkbox"/> Bladder infection</p> <p><input type="checkbox"/> Burning with urination</p> <p><input type="checkbox"/> Frequency</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Retention</p> <p><input type="checkbox"/> Urgency</p> <p><input type="checkbox"/> Urinary tract infection</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Neurological:</u></p> <p><input type="checkbox"/> Amnesia</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Parkinson's Disease</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> TIA (transient ischemic attack)</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>

PATIENT NAME: _____

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REVIEW OF SYSTEMS continued (Please mark all that apply. Mark NONE under EACH section if no symptoms are selected)

<p><u>Psychiatric:</u></p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Memory loss</p>	<p><u>Allergy/Immunologic:</u></p> <p><input type="checkbox"/> Food allergy</p> <p><input type="checkbox"/> Latex allergy</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Other _____</p>
<p><u>Skin:</u></p> <p><input type="checkbox"/> Basal Cell Carcinoma <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Birthmarks <input type="checkbox"/> Squamous cell carcinoma</p> <p><input type="checkbox"/> Eczema <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> MRSA <input type="checkbox"/> Other _____</p>	