Midwest Orthopaedic Center, SC

Medical History Form

Patient Name:______________________ DOB:________Appt Date:__________With: Dr. Johnson, Ben Holman PA-C

Age:________ Sex: ☐ F ☐ M Height:________ Weight:________ Dominant hand: ☐ R ☐ L Did you bring X-rays? ☐ Y ☐ N

Primary Physician's First & Last Name: ______________________ ☐ MD ☐ PA

Clinic Name:______________________

What is the reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness Other ____________

Latex Allergy? ☐ Y ☐ N

What body part is involved? (Please mark in the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

How long ago did it start? ______**Days** ______**Weeks** ______**Months** ______**Years.**

Have you had a problem like this before? ☐ Y ☐ N

In this section check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space below as needed.

☐ **NO INJURY** (or onset was: ☐Gradual or ☐Sudden) *Please indicate why do you think it started.*

☐ **INJURY** (☐Accident ☐Sport (Not Auto or Work) Date:_______ *Please specify where and how it happened.*

What Sport? ______________________ School? ______________________

☐ **INJURY AT WORK** Date:_______ From a: ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach

☐ **WORK RELATED** (but no injury) Date:_______ *How did your job cause the problem?*

☐ **AUTO ACCIDENT** Date:_______ *How was your car hit?*

*Comments:*______________________

On a scale of 0-10 (10 being the worst) how severe is your pain? *(circle)* 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning

The pain is: ☐ constant ☐ comes and goes (intermittent) **Does you pain wake you from your sleep?** ☐ Y ☐ N

Do you have: ☐ swelling ☐ bruises ☐ numbness ☐ tingling ☐ weakness ☐ loss control of bowel/bladder ☐ locking/Catching ☐ giving way

Since my problem started, it is getting: ☐ better ☐ worse ☐ unchanged

What makes your symptoms WORSE? ☐ standing ☐ walking ☐ lifting ☐ exercise ☐ twisting ☐ lying in bed ☐ bending ☐ squatting ☐ kneeling ☐ stairs ☐ sitting ☐ coughing ☐ sneezing

Which makes your symptoms BETTER? ☐ rest ☐ elevation ☐ ice ☐ heat ☐ other: ______________

What medications are you taking now?______________________

Allergic to any Medications? ☐ Y ☐ N If yes please list and describe reactions:______________

Have you had any of these treatments? injection: ☐ Y ☐ N brace: ☐ Y ☐ N physical therapy: ☐ Y ☐ N Cane/Crutch: ☐ Y ☐ N

Were you seen in the E.R. for this problem? ☐ Y ☐ N Which E.R.? ______________________ Date: ________

Are you here today as a result of an E.R. Visit? ☐ Y ☐ N Who saw you in E.R.? ______________ ☐ MD ☐ PA

What tests/scans have you had for this problem? ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV) **Where?** ________

Have you already had surgery for a problem in this same area either recently or in the past? ☐ Y ☐ N Please list below:

Procedure #1 ______________ Surgeon ______________ City ______________ Date ________

Procedure #1 ______________ Surgeon ______________ City ______________ Date ________

Current work status? ☐ regular ☐ light duty- (how long? ________) ☐ not working due to this problem ☐ disabled ☐ retired ☐ Student

When is the last date you worked your regular job? ______________

Are you currently receiving or plan to apply for: Disability: ☐ Y ☐ N Worker's Comp: ☐ Y ☐ N Unemployment: ☐ Y ☐ N

MIDWEST ORTHOPÆDIC CENTER

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Review of systems

Patient Name: ______________________________

have you had a prior problem with this same Orthopedic condition in the past? ☐ Y ☐ N (explain below)

____

Do your other joints have: ☐ morning stiffness lasting over 30 minutes ☐ joint pain or swelling ☐ back pain ☐ Gout ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ prior fracture (which bone)______________ ☐ None of these

Have you had any of these symptoms? (If no mark NONE)

				NONE	YEAR	DETAILS / COMMENTS
1) GI	☐ heartburn, ulcers ☐ hepatitis	☐ nausea or vomiting ☐ liver disease	☐ blood in stool	☐	____	______________
2) ENDO	☐ thyroid disease	☐ heat or cold intolerance		☐	____	______________
3) CON	☐ weight loss	☐ loss of appetite		☐	____	______________
4) EYE	☐ blurred vision	☐ double vision vision loss		☐	____	______________
5) ENT	☐ hearing loss	☐ hoarseness	☐ trouble swallowing	☐	____	______________
6) CV	☐ chest pain	☐ palpitations		☐	____	______________
7) RS	☐ chronic cough	☐ shortness of breath		☐	____	______________
8) GU	☐ painful urination	☐ blood in urine	☐ kidney problems	☐	____	______________
9) SK	☐ frequent rashes	☐ skin ulcers ☐ lumps	☐ psoriasis	☐	____	______________
10) NEU	☐ headaches	☐ dizziness	☐ seizures	☐	____	______________
11) PSY	☐ depression	☐ drug/alcohol addiction	☐ sleep disorder	☐	____	______________
12) HEM	☐ easy bleeding	☐ easy bruising	☐ anemia	☐	____	______________

13) ARE YOU HIV POSITIVE: ☐ Y ☐ N

PAST MEDICAL HISTORY

Are you Diabetic? ☐ Y ☐ N If Yes treatment: ☐ insulin ☐ oral meds ☐ diet ☐ none

Are you taking or have you ever taken, blood thinners? ☐ Y ☐ N If yes which one? ______________

Past Surgical History: What operations have you had and when? Please list: ______________

____

Have you or a family member ever had a reaction to anesthesia? ☐ Y ☐ N Explain: ______________

Past Hospitalizations: (Not for Surgery): ______________ ☐ None

Have you ever had: ☐ heart attack (year_____) ☐ high blood pressure ☐ blood clots (year_____) ☐ stroke ☐ heart failure ☐ ankle swelling ☐ kidney failure ☐ cancer (location______________) ☐ stomachache while taking anti-inflammatories (includes Advil/Aleve)

What anti-inflammatories have you already had a problem with? ______________

☐ **I DO NOT HAVE ANY OF THE ABOVE CONDITIONS.**

FAMILY HISTORY: have any direct relatives had any of the following disorders? If so, which relative?

☐ Diabetes ______________ ☐ High Blood Pressure ______________ ☐ Rheumatoid Arthritis ______________ ☐ None

Do any direct relatives have this same condition you are being seen for today? ☐ Y ☐ N

SOCIAL HISTORY: Do you use tobacco? ☐ Y ☐ N If yes, packs per day_____ Patient informed of smoking risk?

Alcohol use? ☐ Y ☐ N If yes how often? ☐ daily other /week

Marital History: ☐ M ☐ S ☐ D ☐ W How many people live with you? ______________

Occupation: ______________ Employer: ______________

Do you plan to be working 6 months from now? ☐ Y ☐ N

☐ **Student**

PLEASE SIGN: The information on this form(s) is accurate to the best of my knowledge.

Patient Signature ______________________________ Date __________

MD/PA Signature ______________________________ Date __________