# THE ORTHOPEDIC CLINIC ASSOCIATION, P.C.
## History & Physical Form

Please provide the following medical information to the best of your ability **(PLEASE PRINT)**

**Patient Name:**________________________________ **PID (if known)** ________ **Date**__________

**Name of Primary Physician**_______________________________________________

**What is your dominant hand?**_________________________ **Age**_______ **Gender** ___________

**What problem(s) are you coming in for?** **When did the problem begin?**

_______________________________________________ _______________________________________________

**How much pain do you have with 0 being no pain and 10 being the worst pain you could have?** _______________

**How did it occur?**________________________________ **Where did it occur?**______________________________

**Was your injury the result of an accident?** _______________**If yes please select** **Auto** **Home** **Work** **Other**

Explain:_____________________________________________________________________________________

What makes it worse? _________________________ What makes it better? ___________________________________

Are there other symptoms? _____ Numbness _______ Weakness ______Swelling ____Loss of joint motion

____Joint locking _____ Joint popping out of place ______Pain radiating to _________________________

**Treatments** you've already tried, including at home exercises or formal physical therapy, please include **dates**:

_____________________________________________________________________________________________

If you've had the following **Tests**, please give **date** and **location**:

X-rays___________________________________________ MRI ___________________________________________

****Review of Systems:** Please place a check next to any of the following that you have had within the last year:

- [ ] Abdominal Pain
- [ ] Bleeding
- [ ] Chest Pain
- [ ] Convulsions / Seizures
- [ ] Decreased Motion
- [ ] Depression
- [ ] Difficulty Swallowing
- [ ] Easy Bruising
- [ ] Emotional Disturbances
- [ ] Eye or Vision Problems
- [ ] Fecal Incontinence
- [ ] Fever / Chills
- [ ] Headaches
- [ ] Increased Thirst
- [ ] Increased Hunger
- [ ] Insomnia
- [ ] Joint Pain
- [ ] Nausea / Vomiting
- [ ] Night Sweats
- [ ] Poor Balance
- [ ] Persistent Cough
- [ ] Rash
- [ ] Shortness of Breath
- [ ] Shortness of Breath while lying down
- [ ] Skin Problems
- [ ] Urinary Retention
- [ ] Weakness

### **PAST MEDICAL HISTORY

**If you have ever been told that you have any of the following conditions, please check the box next to that condition:**

| Condition | | Condition | | Condition | |
|---|---|---|---|---|---|
| Abdominal Aortic Aneurysm | | Gout | | Pacemaker / Defibrillator | |
| Anemia | | Heart Attack | | Peripheral Vascular Disease (PVD) | |
| Anxiety Disorder | | Heart Disease | | Prostate | |
| Asthma | | Type: | | Pregnant | |
| Bladder Infections | | Heart Murmur | | Last Menstrual Period: | |
| Blood Clots / Embolism Hx | | Hepatitis | | Psychological Disorder | |
| Type: | | Type: | | Type: | |
| Blood Disorders | | High Cholesterol | | Rheumatoid Arthritis | |
| Type: | | Human Immunodeficiency Virus (HIV) | | Seizures | |
| Cancer | | Hypertension (high blood pressure) | | Shingles | |
| Type: | | Intestinal Ulcers | | Shortness of Breath | |
| Cardiac Cath | | Kidney Disease | | Sleep Apnea/CPAP/BIPAP (respiratory) | |
| Cerebral Palsy | | Liver Disease | | STD | |
| Chest Pain | | Lupus | | Stroke | |
| Coagulopathy(can't form blood clots) | | Lyme Disease | | Stomach Ulcers | |
| COPD (lung disease) | | Memory Loss | | Thyroid Disease | |
| Coronary Arterial Bypass | | Methicillin Resistant Staph Aureus(MRSA) | | Transient Ischemic Attach (TIA) | |
| Crohn's Disease | | Type: | | T.B. (Tuberculosis) | |
| Depression | | Migraines | | Type: | |
| Diabetes | | Mitral Valve Prolapse | | Vancomycin Resistant Enterococci | |
| Type: | | Neurological (nerve) Disorder | | Other: | |
| Dialysis | | Type: | | | |
| Emphysema/Chronic Bronchitis | | Neuropathy | | | |
| Fibromyalgia | | Osteoarthritis | | | |
| GERD | | | | | |

****PAST SURGICAL HISTORY:**

Please list all your previous **Surgeries** including dates: Mo/Yr Mo/Yr

1. ______________________________ ________ 4. ______________________________ ________
2. ______________________________ ________ 5. ______________________________ ________
3. ______________________________ ________ 6. ______________________________ ________

**Are you Allergic to any of the following:

| Allergen | Yes | No | Specific Substance | Reaction |
|---|---|---|---|---|
| | | | | |
| Iodine | | | | |
| Latex | | | | |
| IVP Dye | | | | |
| Metal / Jewelry Allergy | | | | |
| Food Allergy | | | | |
| Medication Allergy | | | | |
| Anesthesia | | | | |
| Environmental Allergy | | | | |

**Please list any current medications** (Please give dose, times per day taking, and dates started):
*(*MUST include ANY over the counter medications, aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, and nasal sprays/cold/sinus/allergy meds):*

1. ____________ 4. ____________ 7. ____________

2. ____________ 5. ____________ 8. ____________

3. ____________ 6. ____________ 9. ____________

**FAMILY HISTORY**: Do you know if any of your immediate family has ever been told they have any of the following?

| | Mother | Father | Brother / Sister | Grandparents |
|---|---|---|---|---|
| Diabetes | | | | |
| Hemophilia | | | | |
| Rheumatoid Arthritis | | | | |
| Cancer | | | | |
| Stroke | | | | |
| Heart Disease | | | | |
| Lung Disease | | | | |
| Kidney Disease | | | | |
| Malignant Hyperthermia | | | | |
| Anesthetic Reactions | | | | |

**SOCIAL HISTORY:** Do you smoke or drink alcohol?

Are you a current smoker? ☐ Yes ☐ No Year Started? ☐ Cigarettes? Amt: ☐ Packs/day or ☐ Cigarettes/day
Cigars? Amt: ☐ # per day
Are you a previous smoker? ☐ Yes ☐ No Year Quit? ☐ Packs per year? ☐
Do you use smokeless tobacco? ☐ Yes ☐ No Amount per day? ☐
Do you drink alcohol? ☐ Yes ☐ No Drinks per day ☐ Drinks per week ☐

Have you fallen in the last 12 months? ☐ Yes ☐ No
Have you fallen more than once or been injured in the last 12 months? ☐ Yes ☐ No
Do you have a Living Will or Power of Attorney? ☐ Yes ☐ No

**If you have had a Flu Vaccination, date of your last Flu Vaccination** ____________

**If 65 or older, date of your last Pneumonia Vaccine** ____________ **Last Tetanus Shot** ____________

**Occupation:** ____________ **Work:** ____________

**Do you exercise regularly?** ____________ **Sports you participate in:** ____________

**Height:** ____________ **Weight:** ____________

**Mammogram (females 40 yrs and older)** ☐ Yes ☐ No ☐ Date ☐ Patient Declined ☐ Normal ☐ Bilateral Mastectomy ☐ Abnormal ☐ Right and Left Mastectomies

**Authorization to E-Prescribe:** I understand that my physician may be sending prescriptions and refill medications through an e-prescribing system electronically. I have been informed on the e-prescribing process. I also give permission for The Orthopedic Clinic Association PC to obtain my medication history from the pharmacy, my health plans, and my other healthcare providers. ______**(Initial)**

**Please list your pharmacy with address and phone number:** ____________

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****IF YOU HAVE TRIED ANY OF THE FOLLOWING CONSERVATIVE TREATMENTS, PLEASE MARK IF THEY PROVIDED ANY RELIEF:**

Have you attempted greater than 3 months of conservative care? ☐

| | | | |
|---|---|---|---|
| Have you tried Accupuncture? | ☐ Yes ☐ No | Did this provide relief? | ☐ Yes ☐ No |
| Have you tried an ace wrap? | ☐ Yes ☐ No | Did this provide relief? | ☐ Yes ☐ No |
| Have you tried braces? | ☐ Yes ☐ No | Did this provide relief? | ☐ Yes ☐ No |
| Have you tried heat? | ☐ Yes ☐ No | Did this provide relief? | ☐ Yes ☐ No |
| Have you tried ice? | ☐ Yes ☐ No | Did this provide relief? | ☐ Yes ☐ No |
| Have you tried a TENS Unit? | ☐ Yes ☐ No | Did this provide relief? | ☐ Yes ☐ No |
| Have tried joint injections? | ☐ Yes ☐ No | Did this provide relief? | ☐ Yes ☐ No |

**Type of medication injected:**

☐ Cortisone/ Steroid ☐ Euflexxa ☐ Hyalgan
☐ Monovisc ☐ Orthovisc ☐ Supartz
☐ Synvisc ☐ Unknown ☐ Other:

**Body Part Injected:**________________ **When?**________

Have you tried oral medications? ☐ Yes ☐ No  Did this provide relief? ☐ Yes ☐ No

**Type of medication taken:**

☐ Aspirin (Anacin, Ascriptin, Bayer, Bufferin, Ecotrin, Excedrin) ☐ Celebrex ☐ Voltaren ☐ Voltaren XR
☐ Ibuprofen (Advil, Motrin, Motrin IB, Nuprin ☐ Aleve ☐ Anaprox ☐ Daypro
☐ Naproxen (Naprosyn, Naprelan) ☐ Feldene

**How long have you been taking these medications?**

☐ 3 months ☐ 6 months ☐ 9 months ☐ 1 year ☐ More than 1 year

Have you tried Physical Therapy? ☐ Yes ☐ No  Did this provide relief? ☐ Yes ☐ No

When? (Please provide dates):______________________________

Patient did not start physical therapy due to: ☐ Cost ☐ Unaware it was ordered ☐ Work Schedule ☐ Not covered by insurance

Have you tried a home exercise program? ☐ Yes ☐ No  Did this provide relief? ☐ Yes ☐ No

When? (Please provide dates):______________________________

Have you had an aspiration? ☐ Yes ☐ No  Did this provide relief? ☐ Yes ☐ No

Does pain interfere with Activities of Daily Living? ☐ Yes ☐ No

Are you planning on having a Knee Replacement within 6 months? ☐ Yes ☐ No ☐ Unknown

______________________________ ______________________________

**Patient Signature/Legal Guardian Date** **Physician Signature Date**