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 # per day ☐ Cigarettes/day

Cigars? Amt: ☐

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

Occupation: ________________ **Work:** ______________________

Do you exercise regularly? ________ **Sports you participate in:** ______________________

Height: ____________ **Weight:** ________________

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: ____

____

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

Patient tried acupuncture and it provided relief?	☐ Yes	☐ No	☐ Sometimes
Patient tried an ace wrap and it provided relief?	☐ Yes	☐ No	☐ Sometimes
Patient tried braces and they provided relief?	☐ Yes	☐ No	☐ Sometimes
Patient tried heat and it provided relief?	☐ Yes	☐ No	☐ Sometimes
Patient tried ice and it provided relief?	☐ Yes	☐ No	☐ Sometimes
Patient tried a TENS Unit and it provided relief?	☐ Yes	☐ No	☐ Sometimes
Patient tried joint injections and they provided relief?	☐ Yes	☐ No	☐ Sometimes

Type of medication injected:

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

Body Part Injected:_________________ **When?**_______

Patient tried oral medications and they provided relief?	☐ Yes	☐ No	☐ Sometimes

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

Patient tried Physical Therapy and it provided relief?	☐ Yes	☐ No	☐ Sometimes

When? (Please provide dates):____

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

Patient tried a home exercise program and it provided relief?	☐ Yes	☐ No	☐ Sometimes

When? (Please provide dates):____

____ ____

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