

ORTHOPEDIC SURGERY AND SPORTS MEDICINE CLINIC
NEW PATIENT MEDICAL HISTORY FORM

Date: _____

Patient Last Name: _____ Legal First Name: _____ Middle Initial: _____ Preferred Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: () - _____ Secondary Phone: () - _____ Notify for appointment: phone/text/email

Email: _____ No Email Decline to provide

Social Security #: _____ / _____ / _____ Male Female

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____

Race: African American Asian Caucasian Native American/Alaskan Pacific Islander
 Other _____ Unknown Decline to Answer

Ethnicity: Hispanic Non-Hispanic Unknown Decline to Answer

Preferred Language: English Spanish Chinese Other _____

Marital Status: Married Single Divorced Legally Separated Deceased Other: _____

Primary Doctor: _____ Referring Doctor: _____

Preferred Pharmacy: _____ Phone: () - _____

Emergency Contact: _____ Phone: () - _____

If patient is a minor, please provide the following Guarantor's information:

Guarantor's Name: _____

Social Security #: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Phone: () - _____

Relationship: Mother Father Step Parent Grandparent Other: _____

Primary Insurance: _____

Primary Policy Holder's Name: _____ Date of Birth: _____ / _____ / _____ Relationship: _____

Secondary Insurance: _____

Secondary Policy Holder's Name: _____ Date of Birth: _____ / _____ / _____ Relationship: _____

Is this injury work related: Yes No

If yes, please provide your work comp information. We cannot bill your medical insurance if there is an open claim.

Work Comp Insurance: _____ Claim #: _____

Claim Adjuster Name: _____ Phone: () - _____

Chief Complaint

Dominant Hand: Right Left Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

Pain Numbness/Tingling Fracture Stiffness Other: _____

Shoulder	<input type="radio"/> Right	<input type="radio"/> Left	Pelvis	<input type="radio"/> Right	<input type="radio"/> Left	Neck	<input type="radio"/>
Upper Arm	<input type="radio"/> Right	<input type="radio"/> Left	Hip	<input type="radio"/> Right	<input type="radio"/> Left	Upper Back	<input type="radio"/>
Elbow	<input type="radio"/> Right	<input type="radio"/> Left	Thigh	<input type="radio"/> Right	<input type="radio"/> Left	Mid Back	<input type="radio"/>
Forearm	<input type="radio"/> Right	<input type="radio"/> Left	Knee	<input type="radio"/> Right	<input type="radio"/> Left	Low Back	<input type="radio"/>
Wrist	<input type="radio"/> Right	<input type="radio"/> Left	Lower Leg	<input type="radio"/> Right	<input type="radio"/> Left	Buttocks	<input type="radio"/>
Hand	<input type="radio"/> Right	<input type="radio"/> Left	Ankle	<input type="radio"/> Right	<input type="radio"/> Left	Tail Bone	<input type="radio"/>
Thumb	<input type="radio"/> Right	<input type="radio"/> Left	Foot	<input type="radio"/> Right	<input type="radio"/> Left		
Index	<input type="radio"/> Right	<input type="radio"/> Left	Great Toe	<input type="radio"/> Right	<input type="radio"/> Left		
Middle	<input type="radio"/> Right	<input type="radio"/> Left	2nd Digit	<input type="radio"/> Right	<input type="radio"/> Left		
Third	<input type="radio"/> Right	<input type="radio"/> Left	3rd Digit	<input type="radio"/> Right	<input type="radio"/> Left		
Little	<input type="radio"/> Right	<input type="radio"/> Left	4th Digit	<input type="radio"/> Right	<input type="radio"/> Left		
			5th Digit	<input type="radio"/> Right	<input type="radio"/> Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

No Injury Injury Injury at Work Auto Accident Sport Injury Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: Acute (sudden) Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Have you had a problem like this before? Yes No

Describe: _____

3. Have you been seen in an ER for this problem? Yes No Date: (mm/dd/yyyy)

Treating ER/Urgent Care: (ex. Kootenai Health) _____

Physician's Name: _____

4. Rate the pain (10 being the most pain):

0 1 2 3 4 5 6 7 8 9 10

5. Do the symptoms wake you from sleep?

Yes No

6. Please describe the symptoms:

Sharp Dull Stabbing Throbbing Aching Burning Shooting

7. What is the timing of the symptoms?

Constant Intermittent (comes and goes)

History of Present Illness (continued)

8. Is the problem getting better or worse?

- Getting better Getting worse Unchanged

9. What makes the symptoms worse?

- Squatting Kneeling Sitting Bending Stairs Twisting Moving Lying in bed
 Running Walking Athletics Standing Gripping Lifting Reaching Overhead

10. Are there any other symptoms associated with this problem?

- Redness Bruising Swelling Numbness Stiffness Limping Clicking Locking
 Popping Tingling Weakness Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

- None X-rays MRI CT Scan Nerve Test (EMG/NCV) Bone Scan

Have you had any prior treatment for this problem?

- Yes No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
Heat	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
Rest	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
NSAIDs	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Muscle Relaxers	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Chiropractor	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Physical Therapy	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
HomeExerciseProgram	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Surgery	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Injections	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Bracing	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
TENS unit	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____

Other/Comments: _____

Select all previous hospitalizations/surgeries: None

<input type="radio"/> Aneurysm (Brain) Surgery	<input type="radio"/> Hysterectomy	Orthopedic on side:	Right	Left
<input type="radio"/> Aortic Bypass / Vascular Surgery	<input type="radio"/> LAP Band / Gastric Bypass Surgery	Arthroscopy: Knee	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Appendectomy	<input type="radio"/> Lumpectomy	Arthroscopy: Shoulder	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cataract (Eye) Surgery	<input type="radio"/> Mastectomy	Carpal Tunnel Release	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cholecystectomy (Gallbladder)	<input type="radio"/> Malignancy/Cancer	Rotator Cuff Repair	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Heart Surgery	<input type="radio"/> Stents	Total Hip Replacement	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Hernia Repair		Total Knee Replacement	<input type="radio"/>	<input type="radio"/>
		Total Shoulder Replacement	<input type="radio"/>	<input type="radio"/>
		Spinal Surgery - Indicate Level: _____		

Other Surgery _____

Other Orthopedic Surgery _____

Medical Questions

Mark all that currently apply:

Metal in body Claustrophobic Pregnant Sleep Apnea Uses a CPAP Snores

Are you taking blood thinners? Yes No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

None for all

				None	Comments
1) CON	<input type="radio"/> Weight Loss	<input type="radio"/> Loss of Appetite	<input type="radio"/> Fatigue	<input type="radio"/>	_____
2) EYE	<input type="radio"/> Blurred Vision	<input type="radio"/> Double Vision	<input type="radio"/> Vision Loss	<input type="radio"/>	_____
3) ENT	<input type="radio"/> Hearing Loss	<input type="radio"/> Hoarseness	<input type="radio"/> Trouble Swallowing	<input type="radio"/>	_____
4) CV	<input type="radio"/> Chest Pain	<input type="radio"/> Palpitations		<input type="radio"/>	_____
5) RS	<input type="radio"/> Chronic Cough	<input type="radio"/> Pneumonia	<input type="radio"/> Shortness of Breath	<input type="radio"/>	_____
6) GI	<input type="radio"/> Heartburn, Ulcers	<input type="radio"/> Nausea, Vomiting	<input type="radio"/> Blood in Stool	<input type="radio"/>	_____
7) GU	<input type="radio"/> Painful Urination	<input type="radio"/> Blood in Urine	<input type="radio"/> Kidney Problems	<input type="radio"/>	_____
8) SK	<input type="radio"/> Frequent Rashes	<input type="radio"/> Skin Ulcers	<input type="radio"/> Lumps <input type="radio"/> Psoriasis	<input type="radio"/>	_____
9) NEU	<input type="radio"/> Frequent Falls	<input type="radio"/> Loss of Coordination	<input type="radio"/> Numbness	<input type="radio"/>	_____
	<input type="radio"/> Change in Bowel	<input type="radio"/> Change in Bladder	<input type="radio"/> Dizziness		
10) PSY	<input type="radio"/> Depression/Anxiety	<input type="radio"/> Drug/Alcohol Addiction	<input type="radio"/> Sleep Disorder	<input type="radio"/>	_____
11) ENDO	<input type="radio"/> Fever	<input type="radio"/> Heat or Cold Intolerance	<input type="radio"/> Night Sweats		
12) HEM	<input type="radio"/> Easy Bleeding	<input type="radio"/> Easy Bruising	<input type="radio"/> Anemia	<input type="radio"/>	_____

Family History

Have any direct relatives had any of the following disorders? None for all

Father	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			
Mother	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			
Sibling	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? Current, every day smoker Current, some day smoker Former smoker Never
 Heavy tobacco smoker Light tobacco smoker Chewing Tobacco

Do you drink alcohol? Daily Occasionally Rarely Never

Do you drink caffeinated beverages: No Yes: How many per day? _____

Are you currently working? Yes No Retired Disabled If no, what date did you last work? _____

Please list work restrictions, if any: _____

Occupation: _____ Employer: _____ Student

Do you have any allergies? Yes No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Latex allergy? Yes No

Please list all medications you take on a regular basis: None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a personal history of the following medical conditions? None

<input type="radio"/> Aneurysm Where: _____	<input type="radio"/> Emphysema	<input type="radio"/> Kidney Disease
<input type="radio"/> Angina (Chest Pain)	<input type="radio"/> Epilepsy	<input type="radio"/> Kidney Stones
<input type="radio"/> Arthritis Type: _____	<input type="radio"/> Heart Attack	<input type="radio"/> MRSA Infection
<input type="radio"/> Asthma	<input type="radio"/> Hepatitis Type: _____	<input type="radio"/> Pacemaker
<input type="radio"/> Bone or Joint Infections	<input type="radio"/> HIV / AIDS	<input type="radio"/> Phlebitis (Blood Clots)
<input type="radio"/> Cancer Type: _____	<input type="radio"/> High Cholesterol	<input type="radio"/> Pulmonary Embolism
<input type="radio"/> Chemotherapy / Radiation	<input type="radio"/> Hypertension	<input type="radio"/> Reaction to Anesthesia Type: _____
<input type="radio"/> COPD	<input type="radio"/> Hyperthyroidism	<input type="radio"/> Seizures
<input type="radio"/> Congestive Heart Failure	<input type="radio"/> Hypothyroidism	<input type="radio"/> Stomach Ulcers
<input type="radio"/> Diabetes Type: _____ Last A1C: _____	<input type="radio"/> Stroke / TIA	
	<input type="radio"/> Tuberculosis	

Please list any other conditions or details of conditions marked above:

Please check the box that applies to whom filled out the above information:

Patient Parent/Guardian Legal Representative Other/Relationship: _____

By signing below, I acknowledge that I have completed the questions to the best of my knowledge.

Signature

Date

Printed Name

Note: A valid photo identification and insurance card MUST be presented prior to services being rendered in the clinic.