CENTRAL CAROLINA ORTHOPAEDIC ASSOCIATES, PLLC

ORTHOPAEDIC NEW PATIENT HISTORY

Patient's Last name	First name	Today's Date / /	Family Physician

Patient's Age	Date of Inquiry or when problem started / /	Right or Left Handed?

What is the reason for seeking orthopaedic care?_____

_____

Have any tests been performed? (MRI / CT scan / Bone scan / nerve tests / bone density / etc.) _____

Location of test _____

IF WORK RELATED: Employer _____ Current job

Are you working now? ❑ Yes ❑ No ❑ Regular Duty ❑ Light Duty
Did you have an accident at work? ❑ Yes ❑ No
Is there modified work available? ❑ Yes ❑ No

Did your pain start at work? ❑ Yes ❑ No
Is you injury or pain due to the work you do? ❑ Yes ❑ No
Do you have an attorney for this? ❑ Yes ❑ No

Name of attorney _____

SOCIAL HISTORY **❑ Student** **❑ Single** **❑ Married** **❑ Divorced/Separated** **❑ Widowed**

What is your occupation? _____

How much alcohol do you drink? Amount each day: _____

How much do you smoke? Packs per day: _____ Snuff/Dip? _____

Any history of addiction to drugs? ❑ Yes ❑ No ❑ Pills ❑ Marijuana ❑ IV drugs ❑ Alcohol ❑ In recovery (how long) _____

Are you on disability? Medical/Psycological? _____

ORTHOPAEDIC REVIEW OF SYSTEMS

Constitutional
❑ Chills
❑ Fatigue
❑ Fever
❑ Malaise
❑ Night sweats
❑ Weakness

HEENT
❑ Blurred vision
❑ Double vision
❑ Dysphagia
❑ Ear drainage
❑ Facial pain
❑ Headache
❑ Hearing loss
❑ Hoarseness
❑ Nasal congestion
❑ Ringing in ears
❑ Vertigo
❑ Vision loss

Respiratory
❑ Chest pain (respiratory)
❑ Cough
❑ Dyspries
❑ Recent infections
❑ Known TB exposure
❑ Wheezing

Cardiovascular
❑ Chest pain
❑ Cyanosis
❑ Heart murmer
❑ Irregular heartbeat/palpitations
❑ Leg swelling
❑ Syncope

Gastrointestinal
❑ Abdominal pain
❑ Constipation
❑ Blacktarry stool
❑ Diarrhea
❑ Heartburn
❑ Jaundice
❑ Loss of appetite
❑ Nausea
❑ Vomiting

Genitourinary
❑ Dysuria
❑ Frequent urination
❑ Hematuria
❑ Nocturia
❑ Urge incontinence
❑ Urinary incontinence

Integumentary
❑ Breast lump
❑ Contact allergy
❑ Itchy skin
❑ Rash
❑ Skin infections
❑ Skin lesions

Neurological
❑ Bladder problems
❑ Bowel dysfunction
❑ Difficulty walking
❑ Memory loss
❑ Peresthesia
❑ Seizures
❑ Tremors
❑ Weakness

Musculoskeletal
❑ Back pain
❑ Neck pain
❑ Leg pain
❑ Low back pain
❑ Joint fluid
❑ Joint stiffness

Metabolic/Endocrine
❑ Cold intolerant
❑ Hair loss
❑ Heat intolerant
❑ Polydiosia
❑ Polyuria

Psychiatric
❑ Anxiety
❑ Depression
❑ Insomnia

Hematological
❑ Bleeding
❑ Bruising
❑ Easy bruising
❑ Anemia

Immunological
❑ Asthma
❑ Contact dermatitis
❑ Environmental allergies
❑ Food allergies
❑ Frequent infections, colds
❑ Seasonal allergies

MEDICAL HISTORY Have you ever had any of the following:

❑ Cancer, Radiaton, Chemotherapy
❑ HIV/AIDS
❑ Hepatitis (A, B, C)
❑ Diabetes (Insulin I / no insulin II)
❑ Asthma/COPD/Bronchitis
❑ Tuberculosis (treated / not treated)
❑ Hyperthyroidism, Hypothyroid
❑ Females (under 50) LMP: _____
Are you pregnant? ❑ Yes ❑ No
Have you ever had a bone density test ❑ Yes ❑ No

❑ Osteoporosis
❑ Blood clot (arms/legs/lungs/brain)
❑ Treated
❑ Bleeding problems/blood disorders
❑ Neuropathy (Diabetes, spinal, trauma)
❑ Peripheral vascular disease
❑ Aortic Aneurysm
❑ Lupus
❑ Kidney disease

❑ Sickle Cell Anemia
❑ Ulcer (treated/untreated)
❑ High blood pressure
(treated, medication, diet)
❑ Stroke (Dementia/Alzheimer's)
❑ Heart Disease/Heart Attack (m
❑ Other _____
_____
Raynoud's, scheleroderma, rheumatoid, etc.

SURGICAL HISTORY What operations / surgeries / procedures have you had?
Please give dates:

_____

_____

What broken bones have you had? _____

FAMILY HISTORY Do your immediate relatives have any of the following conditions?

❑ Cancer
❑ Arthritis
❑ Kidney Disease
❑ Diabetes
❑ Stroke

❑ Tuberculosis
❑ COPD
❑ Bleeding problems
❑ Blood clots
❑ Hemophilia

❑ Sickle Cell Anemia
❑ Alzheimer's/Organic Brain Syndrome
❑ Heart Disease
❑ Other _____
_____

What medications/other things are you allergic to?_____

What medications are you currently taking? _____

_____

_____

_____

_____

_____

_____ / / _____
Patient's Signature Date

OFFICE USE ONLY

Height_____ Weight_____ BP_____ HR_____ RR_____ Temp_____