Valdosta Orthopedic Associates

Orthopedic Health History

Date of Visit: ______________________

HISTORY OF CHIEF COMPLAINT

What body part are you being seen for today? ☐ Right ☐ Left ☐ Bilateral _________________

Please explain your reason for today's visit: ____

How did it start? ________________________________ When? ____

Was this caused by an injury? ☐ Yes ☐ No If yes, what is the date of injury? ______________

Have you had any ☐ x-rays, ☐ MRI, ☐ CT for this problem? If yes, when? _________ Where? ____________

Have you attempted any previous treatment? ☐ Injection ☐ Physical Therapy ☐ Surgery ☐Other____Date________________

VITALS

Pain Scale (0 - no pain, 10 - worst pain): 0 1 2 3 4 5 6 7 8 9 10

MEDICATIONS

List all medications you are currently taking. Please include the dosage. ☐ None ☐ See attached list

____ ____
____ ____
____ ____
____ ____

ALLERGIES

List allergies and reactions: ☐ None ☐ Latex ☐ Tape ☐ Iodine/Betadine ☐ Contrast Dye ☐ Egg

Allergy: _______________________________________ Reaction: _____________________________________
Allergy: _______________________________________ Reaction: _____________________________________
Allergy: _______________________________________ Reaction: _____________________________________
Allergy: _______________________________________ Reaction: _____________________________________

PATIENT'S CARE TEAM

Current Primary Care Physician: ____________________ Referred by: ___________________________________

PATIENT'S PHARMACY

Preferred Pharmacy: _____________________________ Phone #: ______________________________________
Secondary Pharmacy: ____________________________ Phone #: ______________________________________

SURGICAL HISTORY

Please check if you have had any of these surgeries in the past: ☐ None

☐ Ankle Surgery ☐ Elbow Surgery ☐ Neck Surgery
☐ Appendectomy ☐ Gallbladder Surgery ☐ Pacemaker

None

☐ Ankle Surgery ☐ Elbow Surgery ☐ Neck Surgery
☐ Appendectomy ☐ Gallbladder Surgery ☐ Pacemaker
☐ Back Surgery ☐ Gastric Bypass ☐ Shoulder Surgery
☐ Breast Surgery ☐ Hand Surgery ☐ Thyroidectomy
☐ Coronary Artery Bypass Graft ☐ Heart Surgery ☐ Tonsillectomy
☐ Carpal Tunnel Release ☐ Hernia Repair ☐ Joint Replacement of:
____
☐ Cesarean Section ☐ Hysterectomy ☐ Bone Surgery of:
____
☐ Defibrillator ☐ Knee Surgery ☐ Other:
____

PAST MEDICAL HISTORY

☐ AIDS/HIV ☐ Diabetes ☐ Kidney Disease ☐ Other:
____
☐ Anemia ☐ Dialysis ☐ Liver Disease ☐ Other:
____
☐ Arthritis ☐ DVT/Phlebitis ☐ Migraine Headaches ☐ Other:
____
☐ Asthma ☐ Fibromyalgia ☐ Osteoarthritis ☐ Other:
____
☐ Bleeding Disorder ☐ GERD ☐ Rheumatoid Arthritis ☐ Other:
____
☐ Blood Clotting Disorder ☐ GI Bleed ☐ Seizures ☐ Other:
____
☐ Blood Thinners ☐ Gout ☐ Stroke ☐ Other:
____
☐ Cancer: ___________ ☐ Heart Disease ☐ Thyroid Disease ☐ Other:
____
☐ COPD ☐ Hepatitis, Type: ____ ☐ Ulcers ☐ Other:
____
☐ Depression/Anxiety ☐ Hypertension ☐ Other: ______________ ☐ Other:
____

FAMILY HISTORY

Please tell us about any family members who have or have had major health problems: ☐ Unknown/Adopted

Mother: ☐ Alive ☐ Deceased ☐ No current problems or disability

Health Problems:
____

Father: ☐ Alive ☐ Deceased ☐ No current problems or disability

Health Problems:
____

Siblings: ☐ Brother ☐ Sister ☐ Alive ☐ Deceased ☐ No current

Health Problems:

____

Siblings: ☐ Brother ☐ Sister ☐ Alive ☐ Deceased ☐ No current problems or disability

Health Problems:

____

SOCIAL HISTORY

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Current Every day Smoker
☐ Current Some Day Smoker ☐ Smoker - current status unknown ☐ Unknown if ever smoked

How much do you smoke?: ______ cigarettes per day ______ packs per day ______ packs per week

Has smoked for ___________years Chewing tobacco?: ☐ None ☐ ______ per day ☐ ______ per week

Illicit Drugs: ______________________________ Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

How often do you drink more than 4 to 5 drinks? ☐ None ☐ Weekly ☐ Monthly

Do you have an advanced directive (living will)? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Hand Dominance: ☐ Right ☐ Left ☐ Bilateral

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Are you currently employed?: ☐ Yes ☐ No Employer: ____

Occupation: ____

Are you currently pregnant?: ☐ Yes ☐ No ☐ Unsure

Is this a work related injury?: ☐ Yes ☐ No Is this a motor vehicle accident related injury?: ☐ Yes ☐ No

If you were injured, is litigation ongoing? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Have you experienced any of these symptoms recently? Please mark yes or no.

Reported by: ☐ Patient ☐ Parent ☐ Caregiver

Yes	No	
		Constitutional
☐	☐	fever
☐	☐	night sweats
☐	☐	significant weight gain: ______ lbs
☐	☐	significant weight loss: ______ lbs
		Eyes
☐	☐	vision change
		Ears, Nose Mouth, Throat
☐	☐	difficulty hearing
☐	☐	nose problems
☐	☐	sinus problems
		Cardiovascular
☐	☐	chest pain
☐	☐	palpitations
		Respiratory
☐	☐	cough
☐	☐	shortness of breath
☐	☐	coughing up blood
		Gastrointestinal

Yes	No	
		Genitourinary
☐	☐	incontinence
☐	☐	difficulty urinating
		Integumentary
☐	☐	rashes
		Neurologic
☐	☐	loss of consciousness
☐	☐	weakness
☐	☐	numbness
☐	☐	dizziness
☐	☐	frequent or severe headaches
		Endocrine
☐	☐	fatigue
		Hematologic/Lymphatic
☐	☐	swollen glands
		Allergic/Immunologic
☐	☐	runny nose
☐	☐	itching
☐	☐	hives

☐ ☐ itching
☐ ☐ hives
☐ ☐ frequent sneezing

Gastrointestinal

☐ ☐ abdominal pain
☐ ☐ vomiting
☐ ☐ diarrhea

Patient Signature: ______________________________ Date: ____________________

Parent/Caregiver Signature: ______________________________ Date: ____________________

Parent/Caregiver Printed Name: ______________________________

Provider Signature: ______________________________