|  |  |
| --- | --- |
| **DATE: \_\_\_/ \_\_\_/ \_\_\_**  | **NORTHWEST ORTHOPAEDIC SPECIALISTS, PS Medical History** |

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **[ ]  Male** **[ ]  Female DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Chief Complaint: | [ ]  Right | [ ]  Left | Body Part:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Current **HEIGHT**:\_\_\_\_\_\_\_\_\_\_\_\_ | Current **WEIGHT:\_\_\_\_\_\_\_\_\_\_** |
| **PHARMACY: *Please provide us with the name and location of your pharmacy*** |
| Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ALLERGIES:** **[ ]  NONE KNOWN or:**

|  |  |  |
| --- | --- | --- |
| **[ ]  Penicillin,** reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]  Codeine,** reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]  Latex,** reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **[ ]  Sulfa,** reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]  Oxycodone,** reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]  Tapes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **[ ]  Iodine contrast,** reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]  Hydrocodone,** reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |

**CURRENT MEDICATIONS: *INCLUDE THE DOSE AND HOW OFTEN THE MEDICATION IS TAKEN***

**(Include Over the Counter Products and Supplements) If insufficient space please use back side of page.**

|  |
| --- |
| **LIST ALL BELOW,** **[ ]** See Attached / Scanned List  **OR [ ]  NOT TAKING ANY MEDICATIONS** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **VACCINES:**  |
| **Have you ever had:** | Influenza(Flu) immunization [ ]  Yes [ ]  No | Pneumococcal (pneumonia) vaccine [ ]  Yes [ ]  No |

**FAMILY HISTORY: [ ]  NONE**

|  |  |  |
| --- | --- | --- |
| [ ]  Bleeding problems | [ ]  Blood clotting disorder | [ ]  Complications of anesthesia, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Diabetes | [ ]  Heart disease | [ ]  Malignant hyperthermia | [ ]  Osteoporosis | [ ]  Pulmonary embolism |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PERSONAL / SOCIAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| Are you:  | [ ]  Left handed  | [ ]  Right handed |
| Relationship status: | [ ]  Single | [ ]  Married | [ ]  Divorced | [ ]  Separated | [ ]  Widowed |
| Residence: | [ ]  Alone | [ ]  With others | [ ]  Nursing home | [ ]  Retirement home  | [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employed: | [ ]  No | [ ]  Yes | Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Children: | [ ]  No | [ ]  Yes | Number of Children? \_\_\_\_\_\_\_\_\_\_\_\_ |
| If female, pregnant?  | [ ]  No | [ ]  Yes  |  |
| Do you have an Advanced Directive? | [ ]  No | [ ]  Yes |
| Smoking / tobacco history: | [ ]  No history of tobacco use | [ ]  Quit smoking/tobacco. How long ago did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  Current tobacco use | [ ]  Cigarettes \_\_\_\_ packs a day for \_\_\_ years [ ]  Cigars \_\_\_\_ years |
|  |  | Smokeless tobacco: [ ]  Patches [ ]  Chewing tobacco [ ]  E-cigarettes \_\_\_\_\_years |
|  |  | [ ]  Marijuana use |
| Alcohol Consumption: | [ ]  None | [ ]  Occasional | [ ]  Moderate | [ ]  Heavy |
| History of Substance Abuse: | [ ]  No | [ ]  Yes | If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Exercise level? | [ ]  None   | [ ]  Occasional | [ ]  Moderate | [ ]  Heavy |

**SURGICAL HISTORY:**

|  |
| --- |
| ***Please describe below any orthopaedic surgeries include the procedure and the year*** |
| **HIP :** |  |
| **KNEE:** |  |
| **SHOULDER:** |  |
| **Other Orthopaedic Surgeries:** |  |
| **SPINE SURGERY:** | Type & year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please mark or list any other surgeries you have had in the past:** |
| [ ]  Appendectomy | [ ]  Tonsillectomy | [ ]  Gallbladder | [ ]  Bypass / Heart surgery, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Hysterectomy | [ ]  Oophorectomy | [ ]  C-section | [ ]  Angioplasty / Stent, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Hernia | [ ]  Mastectomy | [ ]  Varicose Veins |  |
| **Other surgeries not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PAST MEDICAL HISTORY: [ ]  NO ILLNESSES** *(Please check all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  AIDS / HIV | [ ]  Dentures/Partials\* | [ ]  Hepatitis [ ] A [ ] B [ ] C | [ ]  Pressure Ulcers |
| [ ]  Anxiety | [ ]  Depression | [ ]  High blood pressure\* | [ ]  Prior nerve injury |
| [ ]  Asthma\* | [ ]  Diabetes | [ ]  MI (Heart Attack) | [ ]  Psoriasis |
| [ ]  Bladder / Kidney infection | [ ]  Dizziness | [ ]  MRSA | [ ]  Pulmonary embolism |
| [ ]  Bleeding disorders | [ ]  Emphysema | [ ]  MVP – Mitral Valve Prolapse | [ ]  Seizures/Epilepsy |
| [ ]  Blood Clots (DVT) | [ ]  Fractures – List types: | [ ]  Malignant hyperthermia\* | [ ]  Shortness of breath\* |
| [ ]  Blood transfusion\* |  | [ ]  Mental / nervous disorder\* | [ ]  Sleep apnea\* [ ] CPAP\* [ ]  BiPAP\* |
| [ ]  Bronchitis | [ ]  Frequent cough | [ ]  Narcolepsy\* | [ ]  Sleep disorder\* |
| [ ]  C-Diff [ ]  Active infection [ ]  Successfully treated | [ ]  Frequent headaches | [ ]  Pacemaker\* | [ ]  Thyroid Dysfunction |
| [ ]  General Anesthesia – Has had | [ ]  Paresthesia lower extremity | [ ]  Tuberculosis |
| [ ]  CVA (Stroke) | [ ]  General Anesthesia – nausea/ | [ ]  Parkinson’s | [ ]  Ulcers / reflux\* |
| [ ]  Cancer |  vomitting | [ ]  Peptic Ulcer Disease | Other: |
| [ ]  Chest pain | [ ]  Heart disease\* | [ ]  Pneumonia |  |
| [ ]  Chronic back/neck pain | [ ]  Heart murmur/irregular rhythm\* | [ ]  Poor leg circulation |  |

**REVIEW OF SYMPTOMS: (Please check all that apply within the last 30 days)**

|  |  |  |
| --- | --- | --- |
| **Constitutional:** **[ ]  NONE** | **Gastrointestinal: [ ]  NONE** | **Integumentary: [ ]  NONE** |
| [ ]  Fever | [ ]  Nausea | Skin |
| [ ]  Night sweats | [ ]  Vomiting |  [ ]  Rash |
| [ ]  Significant weight gain | [ ]  Constipation |  [ ]  Laceration |
| [ ]  Significant weight loss | [ ]  Change in appetite |  [ ]  Non-healing areas |
| [ ]  Exercise intolerance | [ ]  GERD |  [ ]  Psoriasis |
| [ ]  Chills |  |  |
| [ ]  Malaise (general feeling of discomfort) | **Genitourinary Problems:** **[ ]  NONE** | **Neurologic:** **[ ]  NONE** |
|  | [ ]  Incontinence | [ ]  Weakness |
| **Cardiovascular:** **[ ]  NONE** | [ ]  Difficulty urinating | [ ]  Numbness / tingling |
| [ ]  Chest pain / pressure\* | [ ]  Increased frequency of urination | [ ]  Seizures |
| [ ]  Shortness of breath while walking |  | [ ]  Gait dysfunction |
| [ ]  Shortness of breath while lying down | **Musculoskeletal:** **[ ]  NONE** |  |
| [ ]  Palpitations | [ ]  Muscle aches  | **Neurologic: [ ]  NONE** |
| [ ]  Heart murmur | [ ]  Muscle weakness  | [ ]  Depression |
| [ ]  Ankle swelling | [ ]  Joint pain | [ ]  Alcohol abuse |
|  | [ ]  Back pain | [ ]  Anxiety |
| **Respiratory:** **[ ]  NONE** | [ ]  Swelling of extremities  | [ ]  Memory loss |
| [ ]  Cough | [ ]  Neck pain | [ ]  Dementia |
| [ ]  Wheezing | [ ]  Difficulty walking |  |
| [ ]  Shortness of breath\* | [ ]  Cramps | **Circulation Problems:** **[ ]  NONE** |
| [ ]  Sleep apnea\* [ ]  CPAP\* [ ]  BiPAP\* | **[ ]** Osteoporosis | [ ]  Excessive bleeding |
|  | [ ]  Fractures | [ ]  Anemia |
|  |  | [ ]  Phlebitis |
| Other: |  |