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

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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** | | | | |
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|  | |  | |  |
| **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:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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)*

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| --- | --- | --- | --- |
| 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)**

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| --- | --- | --- | --- |
| **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: |  | | |