Susquehanna Orthopaedic Associates

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: ○ Caucasian ○ African American ○ Asian ○ Native American ○ Other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Other _____

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Chief Complaint

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

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○	Right	○	Left	Pelvis	○	Right	○	Left	Neck	○
Upper Arm	○	Right	○	Left	Hip	○	Right	○	Left	Upper Back	○
Elbow	○	Right	○	Left	Thigh	○	Right	○	Left	Mid Back	○
Forearm	○	Right	○	Left	Knee	○	Right	○	Left	Low Back	○
Wrist	○	Right	○	Left	Lower Leg	○	Right	○	Left	Buttocks	○
Hand	○	Right	○	Left	Ankle	○	Right	○	Left	Tail Bone	○
Thumb	○	Right	○	Left	Foot	○	Right	○	Left		
Index	○	Right	○	Left	Great Toe	○	Right	○	Left		
Middle	○	Right	○	Left	2nd Digit	○	Right	○	Left		
Third	○	Right	○	Left	3rd Digit	○	Right	○	Left		
Little	○	Right	○	Left	4th Digit	○	Right	○	Left		
					5th Digit	○	Right	○	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. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

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

Describe:

4. Have you been seen in an ER? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ **Date:** (mm/dd/yyyy) _____

 Patient Name: _____

History of Present Illness (continued)

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

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep?

○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

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

11. 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? ○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ No ○ Yes If you answered yes the to above question, please list the Name of the Physician _____ Date Last Seen _____

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	
Chiropractor	○ Improved	○ Worsened	○ Unchanged	
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	
Home Exercise Program	○ Improved	○ Worsened	○ Unchanged	
Surgery	○ Improved	○ Worsened	○ Unchanged	
Injections	○ Improved	○ Worsened	○ Unchanged	
Bracing	○ Improved	○ Worsened	○ Unchanged	
TENS unit	○ Improved	○ Worsened	○ Unchanged	

Other/Comments:

 Patient Name: _____

Select all previous hospitalizations/surgeries: ○ **None**

○ Aneurysm (Brain) Surgery	○ Hernia Repair - Inguinal
○ Angioplasty	○ Hernia Repair - Abdominal
○ Aortic Bypass / Vascular Surgery	○ Hysterectomy
○ Appendectomy	○ LAP Band / Gastric Bypass Surgery
○ Cataract (Eye) Surgery	○ Lumpectomy
○ Cesarean	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Defibrillator	○ Pacemaker
○ Heart Surgery	○ Stents - Cardiac / Peripheral

Orthopedic on side:	**Right**	**Left**
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
Total Shoulder Replacement	○	○
○ Fixation of Fracture - Where		
○ 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) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	
2) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats	○	
3) CON	○ Weight Loss	○ Weight Gain	○ Fatigue ○ Incontinence	○	
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss	○	
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	
6) CV	○ Chest Pain	○ Palpitations		○	
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	
10) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	
	○ Change in Bowel	○ Change in Bladder	○ Dizziness		
11) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	
12) HEM	○ Anemia	○ Easy Bruising	○ Blood Clots	○	
13) MUS	○ Bone Pain	○ Muscle Pain	○ Joint Pain	○	

 Patient Name: _____

Family History

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

Father	○ None	○ Bleeding Problems	○ Blood Clots	○ Cancer	○ Connective Tissue
	○ Diabetes	○ Epilepsy	○ Heart Disease	○ Hypertension	○ Muscular Dystrophy
	○ Osteoporosis	○ Rheumatoid Arthritis	○ Stroke		
	Comments (ex. cancer type) _____				
Mother	○ None	○ Bleeding Problems	○ Blood Clots	○ Cancer	○ Connective Tissue
	○ Diabetes	○ Epilepsy	○ Heart Disease	○ Hypertension	○ Muscular Dystrophy
	○ Osteoporosis	○ Rheumatoid Arthritis	○ Stroke		
	Comments (ex. cancer type) _____				
Sibling	○ None	○ Bleeding Problems	○ Blood Clots	○ Cancer	○ Connective Tissue
	○ Diabetes	○ Epilepsy	○ Heart Disease	○ Hypertension	○ Muscular Dystrophy
	○ Osteoporosis	○ Rheumatoid Arthritis	○ Stroke		
	Comments (ex. cancer type) _____				

Social History

Do you use tobacco? ○ Unknown ○ Never ○ Former smoker ○ Daily ○ Occasionally

If you are a current smoker, indicate how many cigarettes per day do you smoke? ○ Less than 10 ○ 10 or More

Are you exposed to second hand smoke? ○ Yes ○ No

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Do you drink caffeinated beverages? ○ No ○ Yes How much? ○ 1-2 cups/cans ○ 3-4 cups/can ○ 5+ cups/can

Recreational drug use? ○ No ○ Yes ○ Prior use

What is your level of Education/School? ○ N/A ○ Current Student ○ Less than 12th Grade ○ High School ○ Trade / Vocational ○ College ○ Professional

What is your marital status? ○ Single ○ Married ○ Divorced ○ Widowed

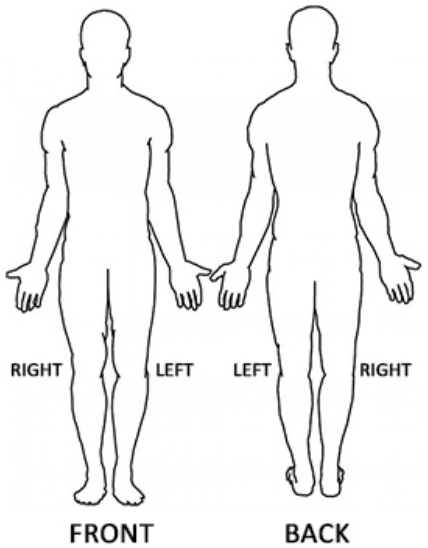
Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

Please list work restrictions, if any: _____

Occupation: _____ **Employer:** _____ ○ **Student**

Pain Diagram

Aching	^^^^
Numbness	- - - -
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



 Patient Name: _____

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

Medication, Relevant Food, or "Seasonal"	Reaction

○ Latex allergy ○ Adhesive tape ○ Anesthesia ○ Iodine / Contrast dyes

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 any of the following? ○ **None**

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

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

_____

_____

_____

_____

_____ _____

Signature **Date**