TRI-STATE ORTHOPAEDICS
& ORTHOPAEDIC URGENT CARE

# MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____
OCCUPATION/SCHOOL: _____ CURRENT GRADE IN SCHOOL: _____
REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

**HABITS:**

WHICH HAND DO YOU WRITE WITH? ☐ RIGHT ☐ LEFT
DO YOU USE E-CIGS? ☐ W/Nicotine ☐ W/O Nicotine ☐ NO
DO YOU USE TOBACCO? ☐ YES ☐ NO ☐ CHEW ☐ Packs per day _____ For how many years? _____
DO YOU DRINK ALCOHOL? ☐ YES ☐ NO How often? _____ How much? _____
WHO LIVES WITH YOU? _____
WHAT MEDICAL PROBLEMS RUN IN YOUR FAMILY? (1)_____(2)_____(3)_____
DO YOU HAVE ANY PERTINENT SOCIAL OR FAMILY HISTORY RELATIVE TO YOUR CLINICAL SITUATION?
☐ YES ☐ NO _____

| | NAME OF DRUG | TYPE OF REACTION | DO YOU HAVE? | REACTION |
|---|---|---|---|---|
| **ALLERGIES** | | | ☐ Dye/Iodine Allergy | |
| | | | ☐ Latex Allergy | |
| ☐ **NO ALLERGIES** | | | ☐ Nickel Allergy | |

**MY MEDICAL PROBLEMS (NOT MY FAMILY):** ☐ **NONE**

Check if yes to any of the following:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | asthma | 493.90 | ☐ | mental health condition | |
| ☐ | copd/emphysema | 496.0/492.8 | ☐ | Alzheimer's/or other dementia | |
| ☐ | high blood pressure | 401.9 | ☐ | post-traumatic stress dis. | |
| ☐ | heart disease | 429.9 | ☐ | depression | 309.81 |
| ☐ | stroke | 438.9 | ☐ | anxiety | 300.4 |
| ☐ | TIA | 435.9 | ☐ | seizures/convulsions | 300.00 |
| ☐ | mitral valve prolapse | 424.0 | ☐ | gallbladder disease (now) | 780.39 |
| ☐ | heart attack | 410.9 | ☐ | dental abscess (now) | 575.9 |
| ☐ | pacemaker/defibrillator | V45.0/V45.2 | ☐ | glaucoma | 522.5 |
| ☐ | atrial fibrillation | 427.31 | ☐ | kidney disease | 365.9 |
| ☐ | on Coumadin/Plavix | | ☐ | kidney failure | 404.90 |
| ☐ | gout | 274.0 | ☐ | kidney stones | |
| ☐ | diabetes | 250.00 | ☐ | kidney/bladder infections | 592.0 |
| ☐ | need insulin | 250.10 | ☐ | dialysis (end stage renal dis) | 595.9 |
| ☐ | diverticulosis | 562.11 | ☐ | degenerative muscle disease | 586. |
| ☐ | irritable colon (IBS) | 564.1 | ☐ | degenerative nerve disease | 729.9 |
| ☐ | crohn's disease | 555.9 | ☐ | venereal disease (STD) | 349. |
| ☐ | ulcerative colitis | 556.9 | ☐ | hepatitis(A,B,C) | 099.9 |
| ☐ | c. diff colitis | 008.45 | ☐ | AIDS/HIV | 573.3 |
| ☐ | stomach ulcers | 531.9 | ☐ | blood clot/DVT | 444.9/453.40 |
| ☐ | GERD/reflux | 530.81 | ☐ | bleeding disorders | 286.9 |
| ☐ | hiatal hernia | 553.3 | ☐ | hemophilia | 286.9 |
| ☐ | gastritis | 535.5 | ☐ | fibromyalgia | 729.1 |
| ☐ | arthritis type: _____ | _____ | ☐ | multiple sclerosis | 340. |
| ☐ | lupus | 710.0 | ☐ | thyroid disease | |
| ☐ | ankylosing spondylitis | 720.0 | ☐ | polio | 780.57 |
| ☐ | obesity | 278.00 | ☐ | sleep apnea | 780.57 |
| ☐ | high cholesterol/lipids | 272.0/272.4 | ☐ | Do you use a C-Pap machine? | |
| ☐ | parkinson's | 332.0 | ☐ | chronic fatigue syndrome | 780.71 |
| ☐ | history of alcohol/drug abuse (illegal or prescription) | 305.0 | ☐ | History of Mrsa | 41.12 |

☐ cancer: body part _____ when diagnosed: _____

Other Medical Illnesses: _____

Is there a possibility of pregnancy? ☐ Yes ☐ No

***Office Use Only: I have reviewed the H&P and examined the patient. Include this document with the H&P as reviewed and verified as of the date signed below.***

☐ There are no changes ☐ Changes are: _____

**Time** **Date** **Signature**

**PREVIOUS OPERATIONS:**

| OPERATION | DATE |
|---|---|
| ☐ Tonsillectomy | |
| ☐ Appendectomy | |
| ☐ Gall Bladder | |
| ☐ Fracture Repair | |
| ☐ Breast Biopsy | |
| ☐ Benign ☐ Malignant | |
| ☐ Vascular Bypass (not heart) | |
| ☐ Open heart/Stent/ Pacemaker | |
| ☐ Other: | |
| Operation _____ | Date _____ |
| Operation _____ | Date _____ |

| OPERATION | DATE |
|---|---|
| ☐ Joint Arthroscopy | |
| ☐ Joint Replacement | |
| which joint(s) _____ | |
| ☐ Cancer Surgery _____ | Date _____ |
| ☐ Hysterectomy | |
| ☐ Complete / Partial | |
| ☐ Cancer | |
| ☐ Cesarean Section | |
| Operation _____ | Date _____ |
| Operation _____ | Date _____ |

**Do you have any of the following?**

☐ Disposable infusion pump/pod/monitoring device
☐ Pacemaker/defibrillator
☐ Neurostimulator

If yes to any, provide the following information (or picture of card)

**Serial #** _____
**Model #** _____

**OTHER SPECIALISTS THAT I AM CURRENTLY SEEING**

PHYSICIAN _____ WHY _____
PHYSICIAN _____ WHY _____
PHYSICIAN _____ WHY _____

☐ **NO MEDICATIONS**

| MEDICATIONS | HOW MUCH | HOW OFTEN | HOW LONG | MEDICATIONS | HOW MUCH | HOW OFTEN | HOW LONG |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

☐ **OR attach medications list**

**REVIEW OF SYSTEMS**

**(PATIENT: CHECK ALL WITHIN THIS SECTION THAT YOU ARE CURRENTLY EXPERIENCING)**

**CONSTITUTIONAL**
☐ Fever
☐ Sweats
☐ Chills
☐ Weight loss/Appetite Loss
☐ Fatigue

**ENT**
☐ Ringing in ears
☐ Sore Throat
☐ Hay Fever
☐ Difficulty Swallowing

**CV**
☐ Chest Pain
☐ Irregular Heart Beat
☐ High Blood Pressure
☐ Swollen Ankles

**RESPIRATORY**
☐ Shortness of breath
☐ Smoker
☐ Coughing up Blood
☐ Need or Use Oxygen

**GI**
☐ Poor appetite
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Constipation
☐ Diarrhea
☐ Blood in Stool

**GU**
☐ Frequent Urination
☐ Cannot Empty Bladder
☐ Difficulty Starting Urination
☐ Blood in Urine
☐ Smelly Urine
☐ Cannot Hold Urine

**PSYCHIATRIC**
☐ Trouble Sleeping
☐ Depression
☐ Nervous Breakdown
☐ Psychological problems
☐ Anxious
Other _____

**MUSCULOSKELETAL**
☐ Arthritis
☐ Deformity
☐ Limping
☐ Pain in Joints
☐ Stiffness in Joints
☐ Catching/Popping in Joints
☐ Use Crutches / Walker
☐ Swelling

**NEUROLOGICAL**
☐ Headaches
☐ Dizziness
☐ Black-Out Spells
☐ Numbness-Tingling
☐ Weakness
☐ Loss of Balance
☐ Loss of Bowels/Bladder/Sex

**HEMATOLOGICAL / LYMPHATIC**
☐ Hemophilia
☐ Protein Deficiency
☐ Easy Bruising/Bleeding
☐ Frequent bloody nose

☐ **CHECK HERE IF NONE OF THE ABOVE APPLY**

**Signature:** _____ **Date/Time:** _____