OSNC Orthopaedic Specialists of North County

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Medical Information

Chart: _____

Form must be filled out before you see the physician. The information on the form provides basic information about your orthopedic problem and general health condition. This information is very important and can influence your orthopedic diagnosis and treatment.

Today's date:_____Acct. #:_____Imaging: _____

Name _____Sex:_____Date of birth: _____Age: _____

Referring Doctor: _____

Height: _____Weight: _____Occupation: _____Dominant hand: R L

What type of orthopedic problems are you being seen for?_____

Did your symptoms result from an accident? Yes _____No _____If yes, list dates and nature of accident:

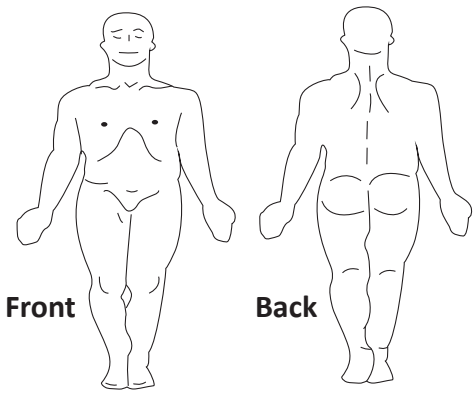
_____

If no, when did your problem first occur: _____

Have you seen a doctor for this problem? Yes _____ No ___

Please rate your pain area on the diagram.

Mark 1 for most painful
Mark 2 for next most painful
Mark 3 for next most painful



How would you describe your symptoms (check all that apply)

☐ Dull ache ☐ Stiffness ☐ 'Giving out" ☐ "Sleepy" ☐ Cold
☐ Sharp ache ☐ Popping ☐ Hot ☐ Weak ☐ Stabbing ☐ Tingling
☐ Tingling ☐ Numb ☐ Cracking ☐ Cramping ☐ Chills

Check the severity of your symptoms:

☐ Mild no compromise of activities ☐ Slight, some compromise of activities
☐ Moderate, marked compromise of activities ☐ Severe—unable to perform activities

Has this been improving? ☐ Improving ☐ Getting worse ☐ Remaining unchanged

How frequent are the symptoms in this area?

☐ Occasional—less than half the day ☐ Intermittent—about half the day
☐ Frequent—more than half the day ☐ Constant—all day and every day

What relieves the symptoms? _____

What makes the symptoms worse? _____

Have you had similar problems before? _____

Medical Information (cont.)

Name: _____ **Date:** _____

Which medical tests or treatments have you received for this problem?

☐ X-ray ☐ CT scan ☐ MRI ☐ Bone scan ☐ CT scan ☐ Blood tests ☐ Nerve tests (EMG)
☐ Myelogram ☐ Nerve injection (nerve root block) ☐ Joint injection ☐ Discogram (X-ray of discs in back)
☐ Other _____

List **ALL surgeries** you have had and the approximate date. (Example: hip replacement, 1999)

_____

_____

List **ALL allergies** and any reactions: _____

_____

List **ALL current medications** you are taking. Include dosage AND time you take them.

Medicine (or herb)	Dosage	Frequency
(Example: Motrin)	**800mg**	**One pill at 8:00 am and one pill at 4:00 pm)**

What <u>active</u> medical conditions do you have (check all that apply)

☐ Diabetes ☐ Rheumatoid arthritis ☐ COPD ☐ Sleep apnea
☐ AFIB ☐ Reflux ☐ Hypertension ☐ Anemia ☐ Other _____

List any serious past medical conditions you may have had _____

_____

List any substance use:	**Currently use**	**Previously used**	**How much**	**How long**	**Stopped**
Tobacco	☐ yes ☐ no	☐ yes ☐ no	_____	_____	_____
Caffeine (coffee, tea, soda)	☐ yes ☐ no	☐ yes ☐ no	_____	_____	_____
Beer, wine, liquor	☐ yes ☐ no	☐ yes ☐ no	_____	_____	_____
Recreation / street drugs	☐ yes ☐ no	☐ yes ☐ no	_____	_____	_____

Family medical history:

Relative	**Currently age**	**(or age at death)**	**Current medical conditions (or cause of death)**
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers/Sister	_____	_____	_____
Children	_____	_____	_____

List hobbies: _____

List any exercise: _____

Check any of these <u>NEW</u> problems that may apply to you:

☐ Weakness/arms ☐ Weakness/legs ☐ Difficulty w/ balance ☐ Fevers ☐ Chills ☐ Sweats ☐ Loss of appetite
☐ Unexpected wt. loss (more than 10 lbs) ☐ History of cancer ☐ Bladder problems ☐ History of steroid use
☐ Constipation ☐ Bowel problems ☐ Pain wakes me up ☐ Fevers ☐ Other: _____

Review of symptoms:

General: ☐weight change ☐other: _____

Skin: ☐rashes ☐lumps ☐sores ☐change in color/size of mole ☐other: _____

Head: ☐headaches ☐head injury ☐other _____

Eyes: ☐sudden loss of vision ☐double vision ☐cataracts ☐glaucoma ☐eye pain ☐eye redness ☐**other:** _____

Ears: ☐sudden loss of hearing cringing ☐vertigo cinfection cdrainage

Nose and sinus: ☐nosebleeds ☐sinus ☐other _____

Mouth and throat: ☐dentures ☐decayed teeth ☐bleeding gums ☐sores in mouth ☐hoarseness ☐difficulty swallowing ☐other _____

Neck: ☐lumps in neck ☐swollen glands ☐goiter ☐pain or stiff neck ☐other

Breasts: ☐lumps ☐nipple discharge ☐dimpled skin ☐other _____

Respiratory: ☐**r**ecurrent cough ☐excessive sputum ☐wheezing ☐asthma ☐emphysema ☐**pneumonia** ☐tuberculosis ☐positive skin test for TB ☐shortness of breath ☐**s**leep apnea ☐other _____

Cardiac: ☐high or low blood pressure ☐rheumatic fever ☐heart attack ☐chest pain at rest or on exertion ☐irregular heart rate ☐swelling of both legs or ankles ☐sleep on two or more pillows ☐high cholesterol ☐other _____

Blood vessels in legs: ☐leg cramps when walking ☐varicose veins ☐cold feet ☐sores on feet or ankles ☐blood clots in legs ☐other

Gastrointestinal: ☐heartburn ☐recurrent nausea or vomiting ☐recurrent constipation or diarrhea ☐rectal bleeding ☐black stool ☐loss of bowel control ☐ulcer ☐hernias ☐abdominal pain ☐jaundice ☐liver or gall bladder problems ☐hepatitis ☐colon polyp/tumor ☐other

Urinary: ☐frequent urination ☐burning on urination ☐recurrent bladder or kidney infections ☐loss of bladder control ☐kidney stones ☐decreased force of urinary stream ☐blood in urine ☐other _____

Male genital: ☐drainage from or sores on penis ☐pain or lump in testicles ☐prostatitis ☐scrotal swelling ☐difficulty in sexual functioning ☐ history of sexually transmitted disease ☐other _____

Female genital: ☐date of last menstruation _____ ☐age at menopause ☐complications of pregnancy ☐drainage from vagina ☐ sores or lumps in and around vagina ☐abnormal bleeding ☐difficulty in sexual function ☐history of sexually transmitted diseases ☐other _____

Nerve problems: ☐black-outs ☐seizure or convulsions ☐paralysis ☐frequent or constant numbness or tingling in a body part ☐abnormal memory loss ☐tremors ☐history of polio or muscular sclerosis or stroke ☐Slurred speech ☐other _____

Blood problems: ☐anemia ☐easy bruising or bleeding ☐splenectomy ☐leukemia ☐other

Other glands: ☐over/under active thyroid ☐diabetes ☐excessive urination ☐sweating or thirst ☐enlarged

Lymph nodes: ☐other _____

Emotional problems: ☐excessive nervousness ☐worry ☐anxiety ☐depression ☐insomnia

Other: _____