# Basic Medical Information Form for Orthopedic Problems

This 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_____________.**

Name_______________________Sex________Date of Birth___________Age______.

Height______Weight______Occupation_________________Dominant Hand______.

| Present Illness | Print or write answer | For Medical Team Use |
|---|---|---|
| What Orthopedic problem are you being seen for today? | | |
| When did it first Occur? | | |
| Where is the problem located Right or left? | | |
| If you have pain:<br>1) Describe (constant, aching, sharp, dull, shooting, burning<br>2) Rate it on a scale of 0 to 10 (O is no pain 10 is worst pain) | | |
| What relieves the symptom? | | |
| What makes symptom worse? | | |
| Have you had a similar problem before? | | |
| What medical test/treatment have you received for this problem? | | |

Other orthopedic problems:

**Circle any of the following that you have or have had. Indicate Right or Left and joint location if applicable next to the condition. Example dislocated joint r-shoulder.**

| | | |
|---|---|---|
| | Gout | Arthritis |
| Recurrent joint swelling | Recurrent joint pain | Dislocated joint |
| Loose pieces in joint | Joint/bone infection | Bone Spars |
| Decreased joint movement | Joint laxity (looseness) | Brittle Bones (osteoporosis) |
| Bursitis/tendonitis | Torn cartilage | Torn Muscle/ligament/tendon |
| Neck/Back pain | Ruptured disc | Abnormal spine curvature |
| Sciatica | Chest Deformity | Amputations |

FOR MEDICAL USE

**Fractures and other serious injuries:**
**(list location and approximate date)**

**Past Surgeries: (list location and approximate date)**

**Other surgery questions:**

Have you received any blood transfusions? List Year

Have you ever had an infection in an incision after surgery? List

Have you ever had problems with anesthesia? List

Have you or a family member ever had a bleeding problem after surgery? List

**Allergies: (list drug or substance and your reaction)**

**Medications**

List all medicines and herbs that you take regularly, check bottle label for dose and time you take it- See example

**MEDICINE/HERB DOSE # OF PILLS TAKEN**

**Other Substances**

Have you used any of the following substances: Circle no or yes and fill in the blanks.

| SUBSTANCE | CURRENTLY USE? | PREVIOUSLY USED? | TYPE/AMOUNT/FRECUENCY | HOW LONG (YRS) | If stopped, when? |
|---|---|---|---|---|---|
| Caffeine: coffee, tea soda | NO YES | NO YES | | | |
| Tobacco | NO YES | NO YES | | | |
| Alcohol: beer, wine, | NO YES | NO YES | | | |
| Recreation/Street drugs | NO YES | NO YES | | | |
| Example Tobacco | (NO) YES | NO (YES) | Cigarettes 1 pack/day | 18 yrs | 1979 |

## Family Medical History:

Circle any of the following conditions that your mother (M), father (F), brother (B) or sister (S) has or had. Next to the condition, indicate which family member has had it.

| | | |
|---|---|---|
| Heart disease | High Blood Pressure | Diabetes |
| Stroke | Bleeding Problems | Arthritis |
| Cancer | Osteoporosis | Other Disease |

## Review of Systems

Circle any symptom/condition which you have had or now have

FOR MEDICAL USE

**General** Weight change, loss of appetite, fever, other____________.

**Skin** Rashes, lumps, sores, change in color or 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, ringing in ears, vertigo
ear infections, drainage from ear, other_________________________.

**Nose and Sinuses**: Nosebleeds, sinus infections, 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** Recurrent cough, excessive sputum, bloody sputum,
wheezing, asthma, emphysema, pneumonia, tuberculosis, positive
skin test for TB, shortness of breath, sleep apnea, other___________.

**Cardiac** high or low blood pressure, rheumatic fever, heart attack,
chest pain at rest or exertion, irregular heart rate, swelling of both
legs/ankles, sleep on two or more pillows, high cholesterol, other___.

**Blood vessels in leg** : 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 stools, loss
of bowel control, ulcers, hernias, abdominal pain, jaundice, liver or
gallbladder 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
testicle, prostatitis, scrotal swelling, difficulty in sexual functioning,
history of sexually transmitted disease, other____________________.

**Female Genital** Date of last menstrual period_________age at
menopause________, complications of pregnancy, drainage from
vagina, sores or lumps in or around vagina, abnormal bleeding,
difficulty in sexual functioning, history of STD's, other_____________.

**Nerve Problem** Blackouts, seizures or convulsions, paralysis,
frequent or constant numbness or tingling in body part, abnormal
memory loss, tremors, history of polio or muscular sclerosis or
stroke/TIA, slurred speech, other______________________________.

**Blood Problems** Anemia, easy bruising or bleeding, splenectomy,
leukemia, other_______________________________________________.

**Other Glands** Overactive/under active thyroid, diabetes, excessive
urination, sweating or thirst, enlarged lymph nodes, other_________.

**Emotional Problems** excessive nervousness, worry or anxiety,
depression, insomnia, other____________________________________.

Reviewed By___________________. Date _______________.

Re-reviewed By_________________, Date _______________.