Orthopaedic Initial History Intake

Patient Name: _____ Date: _____ Provider: _____

Chart #: _____

Age: _____ **F** **M** Height:____/____ Weight _____ lbs

BP_____/_____ Pulse _____
Temp._____ H____/____W_____

Who requested that you visit our office? ☐ Doctor (Name) _____ ☐ Attorney _____

Are you right handed or left handed? ☐ Right ☐ Left ☐ Ambidexterous Shoe Size: _____

✱ What is the main reason for your visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other_____ **(chief complaint)**

✱ What body part is involved? (Location)						
Neck ☐	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
Back ☐ Mid ☐ Lower	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe ☐ R ☐ L

How long has this problem been present? _____ ☐ Days ☐ Weeks ☐ Months

Check the box which **best fits how your problem started**. Then answer the one question below the box you checked.

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden)
Why do you think it started?

☐ **INJURY - Accident or Sport NOT Auto or Work)**
Date_____, Where and How did it happen?
What sport_____ School_____

☐ **INJURY AT WORK**
Date_____, Where and How did it happen?

☐ **WORK RELATED - (BUT NO INJURY)**
Date_____, How did your job cause this problem?

☐ **AUTO ACCIDENT** Date _____, How was your car hit?

ANSWER:

_____
_____
_____
_____
_____
_____
_____
_____

Please check the box below which best describes your problem:

✱ The pain is ☐ Constant ☐ Comes and goes (Intermittent)

✱ **Severity** of pain ☐ 0 (no pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (worst pain)

✱ What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other_____

Are there **associated symptoms**? ☐ Swelling ☐ Numbness ☐ Weakness

Since my problem started, it is: ☐ Getting better ☐ Getting Worse ☐ Unchanged

Does your pain wake you from sleep? ☐ Yes ☐ No

What makes your symptoms **worse**? ☐ Activity ☐ Exercise ☐ Work ☐ Other_____

What makes you feel **better**? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other_____

What medications have you taken or been prescribed for this problem?_____

Check which treatments you have tried? Injection ☐ Y☐ N Brace ☐ Y☐ N Therapy ☐ Y☐ N Cane/Crutch ☐ Y☐ N

✱ *Minimum dictation required for New/Consult Level 3, 4, 5 or Established Level 3, 4, 5*

Turn over for second page >>>

ROS: Please check all symptoms you have experienced in the last MONTH.
PMH: Please check any of the conditions below which you have been diagnosed with.

☐ All ROS is Negative
☐ All PMH is Negative

Musculoskeletal		Gastrointestinal		Eyes
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Pain with walking ☐ Limitation of motion ☐ Myalgia/muscle aches	☐ Rheumatoid arthritis ☐ Osteoarthritis	☐ Blood in stool ☐ Nausea/vomiting ☐ Indigestion or heartburn ☐ Stomach pain with NSAIDS	☐ GERD/Reflux Disease ☐ Ulcers	☐ Glasses/contacts ☐ Double vision

Respiratory		Cardiovascular		ENT
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Persistent cough ☐ Shortness of breath ☐ Wheezing ☐ Recurrent upper respiratory infections	☐ Asthma ☐ COPD ☐ Pneumonia ☐ Sleep Apnea ☐ Use C-PAP	☐ Irregular heart beat ☐ Swelling of feet/ankles/legs ☐ Palpitations ☐ Chest pain or discomfort	☐ Heart Attack/MI ☐ Arrhythmia ☐ Hypertension/High Blood Pressure ☐ Pacemaker/Defibrillator	☐ Hearing loss ☐ Hoarseness ☐ Ringing in ears **PMH** ☐ Deafness

Constitutional/General		Hematology		Skin/Int
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Weight loss ☐ Loss of appetite ☐ Fever/chills	☐ Cancer • Year:_____ • Type:_____	☐ Easy bleeding/bruising ☐ Blood clotting problem ☐ Currently taking blood thinners:_____	☐ Anemia ☐ DVT/Blood clots ☐ Pulmonary Embolism ☐ Ever taken blood thinners: _____	☐ Rash ☐ Lumps

Genitourinary		Endocrine		Immunological
ROS	**PMH**	**ROS**	**PMH**	**ROS**
☐ Pain with Urination ☐ Blood in Urine ☐ Difficulty urinating	☐ Kidney Disease ☐ On Dialysis ☐ Liver Disease	☐ Excessive thirst/fluid intake ☐ Temperature intolerance ☐ Feeling tired (fatigue)	☐ Diabetes (insulin) ☐ Diabetes (non-insulin) ☐ Thyroid Disease	☐ Sinus pressure ☐ Autoimmune disorder

Neurological		Psychological	
ROS	**PMH**	**ROS**	**PMH**
☐ Balance problem ☐ Headaches ☐ Numbness or tingling	☐ Migraines ☐ Seizures ☐ Stroke	☐ Nervousness ☐ Memory loss	☐ Anxiety Disorder ☐ Depression ☐ Psychological Disorder

SURGICAL HISTORY

Prior Non-Orthopaedic Operations: ☐ None _____

Prior Orthopaedic Operations: ☐ None _____

Complications with anesthesia: ☐ No ☐ Yes, reaction: _____

History of malignant hyperthermia? ☐ No ☐ Yes Family history of malignant hyperthermia? ☐ No ☐ Yes

Past Hospitalizations (not for surgery): ☐ No ☐ Yes: _____

SOCIAL HISTORY

Smoking status: ☐Current ☐Former ☐Never Alcohol Use: ☐Not at all Daily:____ Weekly:____ Monthly:_____

Substance/IV Drug History: ☐None ☐Yes, type:_____

How many people live with you: _____ Marital Status: **M S D W** Pregnant: ☐ No ☐ Yes

Are you currently working: ☐ Yes ☐ No Occupation:_____ Employer:_____

If not, how long have you been off work:_____ ☐Student ☐Retired Sports activity:_____

Have you ever received the pneumococcal vaccine: ☐Yes ☐No

Have you had the COVID-19 vaccine? ☐Yes ☐No Which vaccine:_____ Date:_____ Date 2:_____

Have you had 2 or more falls or a fall with injury in the past year: ☐Yes ☐No Date 3:_____

FAMILY HISTORY

Anesthetic Reaction: ☐ Mother ☐ Father Diabetes: ☐ Mother ☐ Father ☐ All Negative

Arthritis: ☐ Mother ☐ Father High Blood Pressure: ☐ Mother ☐ Father

FOR OFFICE USE ONLY

Reviewed by MD _____ Date _____/_____/_____