



NORTHWEST
ORTHOPAEDICS
& SPORTS MEDICINE

Initial Medical History Form

Patient Information

Today's Date _____

Last Name First Name Middle Name Prefers to be Called

Age _____ Sex M F Height _____ Weight _____ BP _____ Temp _____

Date of Birth _____

History of Present Illness

Reason for today's visit: _____

Date of injury or onset: _____ How did the pain begin? _____

Problem due to: car accident work related sports injury fall arthritis other _____

If injured, where did injury occur? home work school N/A other _____

Are you off work due to injury? no yes If yes, last day worked _____

Location of pain: _____ If the problem is related to a limb is it: right left both

Indicate the characteristics that describe your problem:

Pain	Onset	Frequency	Context
<input type="checkbox"/> sharp	<input type="checkbox"/> sudden	<input type="checkbox"/> intermittent	<input type="checkbox"/> standing <input type="checkbox"/> sitting
<input type="checkbox"/> dull	<input type="checkbox"/> slowly	<input type="checkbox"/> constant	<input type="checkbox"/> kneeling <input type="checkbox"/> lying down
<input type="checkbox"/> throbbing	Severity	Timing	<input type="checkbox"/> down stairs <input type="checkbox"/> up stairs
<input type="checkbox"/> aching	<input type="checkbox"/> minor	<input type="checkbox"/> am or <input type="checkbox"/> pm	<input type="checkbox"/> walking <input type="checkbox"/> running
<input type="checkbox"/> burning	<input type="checkbox"/> moderate	<input type="checkbox"/> while sleeping	<input type="checkbox"/> coughing <input type="checkbox"/> lifting heavy object
<input type="checkbox"/> cramping	<input type="checkbox"/> severe	<input type="checkbox"/> after activity	<input type="checkbox"/> straining with a bowel movement
<input type="checkbox"/> other		<input type="checkbox"/> during activity	

Associated Symptoms:

instability weakness stiffness changes in bowel or bladder function fever
 chills grinding popping locking giving way sensitive to touch
 sensitive to temperature limb deformation temperature change nausea
 vomiting rash visual changes visible swelling bruising
 numbness tingling other _____

Does the pain move? no yes Where to? _____

How often do you have the pain? constantly hourly daily weekly

What makes it better: rest heat cold elevation physical therapy braces
 injections medications other _____

What makes the pain worse? _____

Is this the first time you have had a problem with this area? no yes

Describe prior problem: _____

For this problem, have you had any of these tests: X-ray MRI CT Scan Ultrasound
 Bone Scan EMG Nerve Study If so, where? _____

Did you bring them with you? yes no

Prior treatment for the current problem:

oral medication _____ braces _____ injection _____ physical therapy _____
type: _____ how many: _____ for how long _____
where _____
 chiropractor _____ heat _____ cold _____ elevation _____
 cane crutch walker wheelchair other _____

Previous Treating Physician and Phone Number _____

Has a physician recommended that you have surgery for this problem? yes no

Past Medical History: Have you or any family member had any of the following medical problems?

<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>	<u>You</u>	<u>Family</u>
<input type="checkbox"/>	<input type="checkbox"/> Kidney stones	<input type="checkbox"/>	<input type="checkbox"/> Reflux	<input type="checkbox"/>	<input type="checkbox"/> Heart trouble/disease	<input type="checkbox"/>	<input type="checkbox"/> Lyme
<input type="checkbox"/>	<input type="checkbox"/> Endocrine disorders	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Colitis	<input type="checkbox"/>	<input type="checkbox"/> High cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Ulcers
<input type="checkbox"/>	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Emphysema	<input type="checkbox"/>	<input type="checkbox"/> Osteopenia	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Phlebitis	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Atrial fibrillation or irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis
<input type="checkbox"/>	<input type="checkbox"/> Anesthesia problems	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> Blood clots/pulmonary embolism		
<input type="checkbox"/>	<input type="checkbox"/> None of the above			<input type="checkbox"/>	<input type="checkbox"/> Other _____		

Family Medical History: If your parents, grandparents, siblings, or children have any of the medical problems listed above, please explain: _____

Are you pregnant? yes no

Breastfeeding? yes no

Past Surgical History:

Type of Surgery _____ year _____ Type of Surgery _____ year _____

Type of Surgery _____ year _____ Type of Surgery _____ year _____

Type of Surgery _____ year _____ Type of Surgery _____ year _____

Prescription/Non-prescription Medications: (including herbal supplements and vitamins)

Name	Dose	Taken per day	Name	Dose	Taken per day
_____			_____		
_____			_____		
_____			_____		

Allergies:

- None Codeine Shellfish Novocaine Metal/jewelry Aspirin
- Penicillin Iodine Lidocaine Contrast Latex Sulfa
- Local anesthetic Food _____
- Other _____

Type of reaction: _____

Social History:

Occupation _____ Working now? yes no retired disabled

Do you use tobacco? Packs per day ____ quit. If quit, years smoked ____ Pipe? yes no
Smokeless? yes no

Alcohol use: never occasional daily heavy History of alcoholism? yes no

History of drug use? yes no

Marital status: single married divorced widowed

Do you live alone? yes no. If no, who do you live with? _____

Type(s) of exercise/sports activity: _____ how often? _____ per week

Review of Systems: Are you currently having problems with any of the following?

Genitourinary

- blood in urine
- kidney stones
- sexual problems
- testicle pain
- menstrual problems

Constitutional

- weight change
- fever
- chills
- fatigue

Respiratory

- short of breath
- cough
- wheezing
- bronchitis

Ears/Nose/Mouth/Throat

- hearing loss/ ringing
- sinus problems
- nose bleeds
- sore throat

Skin

- rash/itching
- breast lump
- hair change
- nail change

Gastrointestinal

- nausea/vomit
- stomach pain
- rectal bleeding
- bowel problem

Hematologic

- bruise easily
- slow to heal
- enlarged glands

Cardiovascular

- chest pain
- palpitations
- heart trouble
- swelling

Eyes

- glasses/contacts
- blurred vision
- eye disease
- glaucoma

Musculoskeletal

- pain/cramps
- joint swelling
- joint pain
- trouble walking

Neurological

- headaches
- tremors
- seizures
- numbness

Psychiatric

- insomnia
- confusion
- depression

Endocrine

- excessive urination
- thyroid disease
- hormone problem

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

_____/____/____
Patient/Guardian Date

_____/____/____
Medical Professional Date

Provider Statement:

I have reviewed the questionnaire with the patient.

_____/____/____
Signed Date

_____/____/____
Signed Date

_____/____/____
Signed Date

_____/____/____
Signed Date

_____/____/____
Signed Date

_____/____/____
Signed Date