

Chart#: \_\_\_\_\_

# Arthroscopy and Sports Medicine Clinic

## Medical History Form

(Please use black ink)

Patient Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_ with Dr. \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  F  M Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominant hand:  R  L Did you bring X-rays?  Y  N

Who is your primary physician? (name): \_\_\_\_\_  MD  PA Clinic Name? \_\_\_\_\_

What is the reason for this visit?  Pain  Numbness  Weakness  Swelling  Stiffness  Other \_\_\_\_\_

Latex Allergy?  Y  N

What body part is involved? (Please mark the table below)

Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L	Neck <input type="checkbox"/>	Back <input type="checkbox"/>
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How long ago did it start? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years.

Have you had a problem like this before?  Y  N

**In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.**

**NO INJURY** (or onset was:  Gradual or  Sudden)  
Please indicate why do you think it started?

**INJURY** ( Accident  Sport (NOT Auto or Work)  
Date: \_\_\_\_\_ Please specify where and how it happened.  
What Sport? \_\_\_\_\_ School? \_\_\_\_\_

**INJURY AT WORK** Date: \_\_\_\_\_  
From a:  lift  twist  fall  bend  pull  reach

**WORK RELATED (BUT NO INJURY)**  
Date: \_\_\_\_\_ How did your job cause the problem?

**AUTO ACCIDENT** Date: \_\_\_\_\_ How was your car hit?

**COMMENTS:**

On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning

The pain is:  Constant  Comes and goes (intermittent).

Does your pain wake you from your sleep?  Y  N

Do you have:  Swelling  Bruises  Numbness  Tingling  Weakness  
 Loss of control of bowel or bladder  Locking/Catching  Giving way

Since my problem started, it is:  Getting better  Getting worse  Unchanged

What makes your symptoms worse?  Standing  Walking  Lifting  Exercise  Twisting  Lying in bed  
 Bending  Squatting  Kneeling  Stairs  Sitting  Coughing  Sneezing

Which make your symptoms better?  Rest  Elevation  Ice  Heat  Other: \_\_\_\_\_

What medications are you taking now? \_\_\_\_\_

ALLERGIC TO ANY MEDICATIONS?  Y  N if yes please list and describe reaction: \_\_\_\_\_

Have you had any of these treatments? Injection:  Y  N Brace:  Y  N Physical Therapy:  Y  N Cane/Crutch:  Y  N

Were you seen in the E.R. for this problem?  N  Y Which E.R.? \_\_\_\_\_ Date: \_\_\_\_\_

Are you here today as a result of an E.R. Visit?  N  Y Who saw you in E.R.? \_\_\_\_\_  MD  PA

What test/scans have you had for this problem?  
 X-Rays  MRI  CAT Scan  Bone Scan  Nerve Test (EMG/NCV) Where? \_\_\_\_\_

Have you already had surgery for a problem in this same area either recently or in the past?  N  Y

Please list below:  
Procedure #1 \_\_\_\_\_ Surgeon \_\_\_\_\_ City \_\_\_\_\_ Date \_\_\_\_\_  
Procedure #2 \_\_\_\_\_ Surgeon \_\_\_\_\_ City \_\_\_\_\_ Date \_\_\_\_\_

Current work status?  Regular  Light duty - (how long? \_\_\_\_\_)  Not working due to this problem  
 Disabled  Retired  Student

When is the last date you worked your regular job? \_\_\_\_\_

Are you currently receiving or plan to apply for: Disability:  Y  N Worker's Comp:  Y  N Unemployment:  Y  N

Patient Name: \_\_\_\_\_

### REVIEW OF SYSTEMS

Chart#: \_\_\_\_\_

Have you had a prior problem with this same Orthopedic condition in the past?  N  Y (explain below)

**Do your other joints have:**  morning stiffness lasting over 30 minutes  joint pain or swelling  Back Pain  Gout  
 Rheumatoid arthritis  Osteoporosis  prior fracture (which bone) \_\_\_\_\_  None of these

**Have you had any of these symptoms?** If no, mark None.

				NONE	YEAR	Details/Comments
1) <b>GI</b>	<input type="checkbox"/> Heartburn, ulcers	<input type="checkbox"/> Nausea, Vomiting	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/>	_____	<div style="border: 1px solid black; height: 100px; width: 100%;"></div>
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver disease				
2) <b>ENDO</b>	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heat or Cold Intolerance		<input type="checkbox"/>	_____	
3) <b>CON</b>	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite		<input type="checkbox"/>	_____	
4) <b>EYE</b>	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss	<input type="checkbox"/>	_____	
5) <b>ENT</b>	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/>	_____	
6) <b>CV</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations		<input type="checkbox"/>	_____	
7) <b>RS</b>	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/>	_____	
8) <b>GU</b>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney problems	<input type="checkbox"/>	_____	
9) <b>SK</b>	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis	<input type="checkbox"/>	_____	
10) <b>NEU</b>	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/>	_____	
11) <b>PSY</b>	<input type="checkbox"/> Depression	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Sleep disorder	<input type="checkbox"/>	_____	
12) <b>HEM</b>	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia	<input type="checkbox"/>	_____	
13) <b>ARE YOU HIV POSITIVE:</b>				<input type="checkbox"/> N <input type="checkbox"/> Y		

#### PAST MEDICAL HISTORY

**Are you Diabetic?**  N  Y If Yes, treatment:  Insulin  Oral Meds  Diet  None

**Are you taking, or have you ever taken, blood thinners?**  N  Y If yes, which one? \_\_\_\_\_

**Past Surgical History: What operations have you had and when?** Please list: \_\_\_\_\_

**Have you or a family member ever had a reaction to anesthesia?**  N  Y EXPLAIN: \_\_\_\_\_

**Past Hospitalizations:** (Not for Surgery): \_\_\_\_\_  None

**Have you ever had:**  Heart attack (year \_\_\_\_\_)  High Blood Pressure  Blood Clots (year \_\_\_\_\_)  Stroke  Heart Failure

Ankle Swelling  Kidney failure  Cancer (location \_\_\_\_\_)

Stomachache while taking anti-inflammatories (includes Advil/Aleve) What anti-inflammatories have you already had a problem with? \_\_\_\_\_

**I do not have any of the above conditions.**

**FAMILY HISTORY:** Have any direct relatives had any of the following disorders? If so, which relative?

Diabetes \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  Rheumatoid Arthritis \_\_\_\_\_  NONE

Do any direct relatives have the same condition you are being seen for today?  Y  N

#### SOCIAL HISTORY:

**Do you use tobacco?**  N  Y If Yes, packs per day \_\_\_\_\_ **Patient informed of Smoking Risk?**  Y

**Alcohol use?**  N  Y If yes, how often?  Daily  Other \_\_\_\_\_/week

**Marital History:**  M  S  D  W **How many people live with you?** \_\_\_\_\_

**Occupation:** \_\_\_\_\_  Student

**Employer:** \_\_\_\_\_

**Do you plan to be working 6 months from now?**  Y  N

**PLEASE SIGN:** The information on these this form is accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE ONLY

Completed \_\_\_\_\_ Date \_\_\_\_\_

Review #1 by \_\_\_\_\_ MD Date: \_\_\_\_\_ Review #2 by \_\_\_\_\_ MD Date: \_\_\_\_\_