GENERAL NEW PATIENT HISTORY

What is the MAIN injury/problem you are seeing the doctor for today?
IF UNLISTED CHOOSE THE CLOSEST.

- [ ] right shoulder pain
- [ ] left shoulder pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right arm pain
- [ ] left arm pain
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right elbow pain
- [ ] left elbow pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right forearm pain
- [ ] left forearm pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right wrist/hand pain
- [ ] left wrist/hand pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right hip pain
- [ ] left hip pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right thigh pain
- [ ] left thigh pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right knee pain
- [ ] left knee pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right calf pain
- [ ] left calf pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

- [ ] right foot/ankle pain
- [ ] left foot/ankle pain
- [ ] head
- [ ] neck
- [ ] chest
- [ ] midback
- [ ] low back
- [ ] problems walking
- [ ] weakness
- [ ] numbness and/or tingling
- [ ] another problem

Date injury/problem began (APPROXIMATE IF UNSURE): ________________

Is your problem a result of an injury/problem?

- [ ] Yes
- [ ] No

What caused your injury/problem?

- [ ] Fall
- [ ] Lifting
- [ ] Throwing
- [ ] Reaching
- [ ] Pulling
- [ ] Fighting
- [ ] Twisting
- [ ] Sports
- [ ] Collision/Contact
- [ ] Another cause

Other: ________________________

Check any of the following that happened at the time of your injury/problem:

- [ ] Felt pain
- [ ] Heard popping
- [ ] Had swelling
- [ ] Dislocation
- [ ] Fracture
- [ ] Deformity
- [ ] Bruising

What conservative treatment have you had on or since your injury/problem began?

- [ ] Injection
- [ ] Aspiration
- [ ] Physical Therapy
- [ ] Exercise
- [ ] Anti-inflammatory medication
- [ ] Pain Medication
- [ ] Chiropractic Care
- [ ] Bracing
- [ ] Heat
- [ ] Ice
- [ ] Massage
- [ ] Rest
PAIN

Are you having pain today?
○ Yes
○ No

Is your pain today:
○ Occasional
○ Continuous/Constant

On a scale of 0-10 (with 10 being the worst pain imaginable, how would you score your pain today?)
○ 0
○ 1
○ 2
○ 3
○ 4
○ 5
○ 6
○ 7
○ 8
○ 9
○ 10

What time of day is your pain worst?
○ Morning
○ Afternoon
○ Evening
○ Nighttime
○ All the time

Check the words that best describe the character of the pain you are having today:
○ aching pain
○ burning pain
○ exhausting pain
○ gnawing pain
○ miserable pain
○ nagging pain
○ numbness
○ throbbing pain
○ sharp pain
○ stabbing pain

What makes your symptoms better?
○ rest
○ medication
○ ice
○ heat
○ lying down
○ sitting
○ standing
○ walking
○ squatting
○ stretching
○ sports/exercise
○ brace/cane/crutch
○ sleeping
○ physical therapy
○ injection
○ nothing in particular

Other factors that makes the pain better: _________________________________

What makes your symptoms worse?
○ lying down
○ sitting
○ standing
○ walking
○ sports/exercise
○ twisting/pivoting
○ activity in general
○ stooping/bending
○ lifting
○ squatting
○ stairs
○ reaching
○ overhead activity
○ pushing
○ pulling
○ nothing in particular

Other factors that makes the pain worse: _________________________________
## REVIEW OF SYSTEMS

### General
- [ ] no present issues
- [ ] recent weight gain
- [ ] recent weight loss
- [ ] appetite change
- [ ] difficulty sleeping
- [ ] fevers
- [ ] problems walking (balance problems, falling)
- [ ] night sweats

### Eyes
- [ ] no present issues
- [ ] difficulty seeing
- [ ] loss of vision
- [ ] double vision
- [ ] blurred vision

### ENT & Mouth
- [ ] none
- [ ] difficulty hearing
- [ ] nose bleeds
- [ ] swallowing difficulty
- [ ] sinus problems

### Pulmonary (lungs)
- [ ] no present issues
- [ ] shortness of breath
- [ ] dry cough
- [ ] productive cough (sputum)
- [ ] bronchitis
- [ ] asthma
- [ ] sleep apnea

### Gastrointestinal
- [ ] no present issues
- [ ] heartburn / indigestion
- [ ] difficulty swallowing
- [ ] stomach pains
- [ ] ulcers
- [ ] nausea / vomiting
- [ ] diarrhea
- [ ] hemorrhoids
- [ ] rectal bleeding
- [ ] black bowel movements
- [ ] change in bowel habits
- [ ] constipation
- [ ] frequent laxative use
- [ ] jaundice or hepatitis
- [ ] liver trouble
- [ ] gallbladder problems

### Genitourinary
- [ ] no present issues
- [ ] burning on urination
- [ ] frequency of urination
- [ ] difficulty starting urine
- [ ] wetting pants or bed
- [ ] bloody urine
- [ ] sexual difficulties

### Musculoskeletal
- [ ] no present issues
- [ ] joint pain
- [ ] joint deformity
- [ ] joint swelling / warmth
- [ ] joint stiffness
- [ ] muscle pain
- [ ] weakness
- [ ] neck pain
- [ ] back pain

### Hematopoietic / Lymphatic
- [ ] no present issues
- [ ] anemia
- [ ] lymph node enlargement
- [ ] frequent infections
- [ ] excessive bleeding
- [ ] blood clots

### Skin
- [ ] no present issues
- [ ] ecchymotic
- [ ] purulent drainage (pus)
- [ ] swollen
- [ ] erythematous (red)
- [ ] rash
- [ ] itching
- [ ] easy bruising / bleeding
- [ ] slow healing

### Neurologic
- [ ] no present issues
- [ ] headaches
- [ ] dizziness
- [ ] blackouts
- [ ] numbness and tingling
- [ ] paralysis
- [ ] convulsions / seizures
- [ ] coordination trouble

### Endocrine / Metabolic
- [ ] no present issues
- [ ] diabetes
- [ ] goiter
- [ ] thyroid problem
- [ ] sterility
- [ ] cholesterol / lipid problem

### Cardiovascular
- [ ] no present issues
- [ ] high blood pressure
- [ ] chest pain
- [ ] heart attack
- [ ] palpitations (irregular heart beat)
- [ ] heart failure
- [ ] edema (leg swelling)
- [ ] leg cramps (when walking)
- [ ] fainting
- [ ] coldness in hands and/or feet
- [ ] loss of hair on arms or legs
- [ ] abnormal color (blue, white, red) in hands or feet
- [ ] other

### Psychiatric
- [ ] no present issues
- [ ] anxiety
- [ ] depression
- [ ] difficulty sleeping
- [ ] appetite changes
- [ ] confusion
- [ ] memory loss
- [ ] been seen by a psychiatrist
MEDICAL CONDITION HISTORY

☐ NO MEDICAL PROBLEMS
☐ Alcoholism
☐ Anemia
☐ Anxiety
☐ Arthritis – inflammatory (rheumatoid)
☐ Arthritis – oseto, degenerative
☐ Bowel disease
☐ Cancer
☐ Cardiac Arrhythmia (abnormal heart rate)
☐ Congestive Heart Failure
☐ Coronary Artery Disease (Angina)
☐ Cerebrovascular Disease (Stroke)
☐ Diabetes
☐ Depression
☐ Gout
☐ HIV
☐ Hypertension (High Blood Pressure)
☐ Hypercholesterolemia (Elevated Cholesterol)
☐ Hypothyroidism
☐ Kidney Disease
☐ Liver Disease (Cirrhosis, Hepatitis)
☐ Lung Disease (COPD, emphysema)
☐ Osteomyelitis
☐ Parkinson’s
☐ Ulcer Disease
☐ Other: ______________________________

PREVIOUS ORTHOPAEDIC SURGERY/PROCEDURES

Arthroscopy
☐ Right shoulder
☐ Right elbow
☐ Right wrist/hand
☐ Right hip
☐ Right knee
☐ Right foot/ankle
☐ Left shoulder
☐ Left elbow
☐ Left wrist/hand
☐ Left hip
☐ Left knee
☐ Left foot/ankle

Joint Replacement Surgery
☐ Right shoulder
☐ Right elbow
☐ Right wrist/hand
☐ Right hip
☐ Right knee
☐ Right foot/ankle
☐ Left shoulder
☐ Left elbow
☐ Left wrist/hand
☐ Left hip
☐ Left knee
☐ Left foot/ankle

Fracture Repair
☐ Right shoulder
☐ Right elbow
☐ Right wrist/hand
☐ Right hip
☐ Right knee
☐ Right foot/ankle
☐ Left shoulder
☐ Left arm
☐ Left elbow
☐ Left forearm
☐ Left wrist/hand
☐ Left pelvis
☐ Left hip
☐ Left femur (thigh)
☐ Left knee
☐ Left tibia/fibula
☐ Left foot/ankle

Spine Surgery
☐ Cervical
☐ Thoracic
☐ Lumbar

Other Orthopedic Surgeries:

Previous Non-Orthopedic Surgeries
☐ Abdominal surgery
☐ Brain surgery
☐ Cancer surgery
☐ Cardiothoracic surgery
☐ Eye surgery
☐ Gallbladder surgery
☐ Gynecologic surgery
☐ Hernia repair
☐ Plastic surgery
☐ Sinus surgery
☐ tonsillectomy
☐ Urology surgeries
☐ Vascular surgery
☐ Other

Other Surgeries:

_____________________________________________________

_____________________________________________________
FAMILY MEDICAL HISTORY

Please check all diseases for which you have a family history:

- Arthritis, Rheumatoid (inflammatory)
- Arthritis, Degenerative
- Cancer – Breast
- Cancer – Prostate
- Cancer – Other
- Dementia
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Lung Disease
- Stroke
- Dementia
- Other: ___________________________

SOCIAL HISTORY

Current Employment:

- Full time
- Part time
- Retired
- Student
- Unemployed
- Disabled

Level of Education:

- Grade School
- High School/Equivalent
- Some College
- College Degree
- Graduate Degree

Exercise:

- Do not exercise regularly
- Once per week
- 3-5 times per week
- daily

Drugs:

- Do not use drugs
- cocaine
- marijuana
- other

Alcohol:

- Never use alcohol
- Used to drink but stopped
- Rarely drink alcohol (<1/month)
- Drink occasionally (1-4/month)
- Drink socially (1-2/week)
- Drink frequently (3-5/week)
- Drink daily (1/day)

Tobacco:

- does not use tobacco products
- has never smoked tobacco
- uses chewing tobacco
- used to smoke tobacco but stopped
- currently smokes less than ½ pack per day
- currently smokes ½-1 pack per day
- currently smokes 1-2 packs per day
- currently smokes more than 2 packs per day

Other Drugs:

_________________________
MEDICATIONS AND ALLERGIES

Are you currently taking any medications?

[ ] Yes  [ ] No

Patient Current Medications:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>For what purpose?</th>
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<tbody>
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Do you have any allergies?

[ ] Yes  [ ] No

Please list all allergies (including iodine and contract dyes):

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Severity</th>
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<tbody>
<tr>
<td>1</td>
<td>□ Mild □ Moderate □ Severe</td>
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<td>2</td>
<td>□ Mild □ Moderate □ Severe</td>
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<td>3</td>
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<tr>
<td>7</td>
<td>□ Mild □ Moderate □ Severe</td>
</tr>
</tbody>
</table>
Thank you for taking the time to complete this form on your initial visit. The information provided will assist us in ensuring you receive Florida Orthopaedic Institute’s high quality care during your visit with us today. We look forward to keeping you active!

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature: __________________________________________Date:_________