New Problem History

Today's Date:_____ Date of Injury:_____

Your Name:_____

Birthdate:_____

Why do you want to see the Doctor?

What were you doing the first time it hurt?_____

Where is the problem?_____

How long has it been bothering you?_____

When does it bother you?_____

_____

On a scale of 1-10 how bad is it?_____

What is the pain like?_____

Are you in pain management? If so, who is your doctor? _____

Are you in physical therapy?_____ Where? _____

What makes the problem better?_____

What makes the problem worse?_____

Are other things associated with the problem?_____

_____

Have you had this problem before?_____When?_____

Who treated you then?_____

Have you had any tests done?

Type of Test	When?	Where?	What did it show?

Are you seeing another doctor having any other problems with your health ?

Diagnosis? (Diabetes, Blood Pressure, Heart Attack?)	Are you using medicine?	What is the name of the medicine?	Who is the doctor treating you for this?

Is there anything else the doctor should know?

I have answered the questions truthfully and as best I can

Signature:_____ Date:_____

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 203, New Albany, Indiana 47150

PATIENT MEDICATIONS and ALLERGIES

Name_____ Date of Birth_____

Today's Date_____

ALLERGIES

Medication	Reaction (What goes wrong when you use the medicine?)

CURRENT MEDICATIONS

Medication	Dosage	How Often?	For What Condition?

Signature:_____ Date _____

COMPREHENSIVE HISTORY: PATIENT FORM

Today's Date
Name
Age Date of Birth Sex Race
Place of Birth Marital Status Occupation
How did you hear about us?

Past Medical History:
General State of Health Excellent, good, fair, poor (circle one)

Childhood illnesses: measles, German measles, mumps, whooping cough, chickenpox, rheumatic fever, scarlet fever, polio (circle those you have had)

Psychiatric illnesses:

Are you in pain management? If so, who is your doctor?

Immunizations: When was your last tetanus shot_____ , pertussis, diphtheria, polio, measles, German Measles, mumps, hepatitis A, hepatitis B, cholera, typhoid (circle those you have had)

Background History:

Schooling; highest grade completed _____
Military Service _____
Job History _____
Length of employment_____
Marriage_____
Retirement_____

Operations/Surgery

Procedure (what did they do?)	When was it done?	Surgeon	Hospital

Fractures (broken bones)

Which Bone?	When?	Doctor?	Problems now?

Family History

	Age	Illness, Disability, Cause of Death
Mother		
Father		
Spouse		
Child		
Child		
Child		
Child		

The occurrence within the family* of *any of the following conditions *(please circle all that apply):* Diabetes, tuberculosis, heart disease, high blood pressure, stroke, kidney disease, cancer, arthritis, Anemia, headaches, mental illness, symptoms like those you are having, blood clots, bleeding problems

Social History

Diet: excellent, good, fair, poor (circle)
Sleep: excellent, good, fair, poor (circle)
Exercise: regular, sometimes, rarely (circle) type: _____
Use of coffee/tea: _____ cups per day
Alcohol: Type _____ How often? ____ How much? _____
Other Drugs: Type _____
Tobacco: Type_____ How much?_____For how long?_____

Review of Systems (circle all that apply)

General: usual weight ____, recent weight loss, recent weight gain, weakness, fatigue, fever, chronic fatigue syndrome, fibromyalgia

Skin: rashes, lumps, itching, dryness, color change, changes in hair or nails

Head: headache, head injury, migraine headache

Eyes: vision, glasses or contact lenses, last eye examination _____, pain, redness, excessive Tearing, double vision, glaucoma, cataracts

Ears: hearing, ringing in the ears, vertigo, earaches, infection, discharge

Nose and sinuses: frequent colds, nasal stuffiness, hay fever, nosebleeds, sinus trouble

Mouth and throat: change in the condition of teeth and gums,

bleeding gums, sore tongue, Hoarseness, frequent sore throats,

last dental examination_____

Neck: lumps in neck, "swollen glands", goiter, pain in the neck

Breasts: lumps, pain, nipple discharge, self-examination (circle): regularly, irregularly, never

Respiratory: cough, excessive sputum, bloody sputum, wheezing, asthma, bronchitis, emphysema, Pneumonia, tuberculosis, pleurisy, tuberculin test date_____, last chest x-ray date _____

Cardiac: heart trouble, high blood pressure, rheumatic fever, heart murmurs, shortness of breath, number of pillows used at night _____ , edema; chest pain, palpitations; past electrocardiogram or other heart tests, stents

Gastrointestinal: trouble swallowing, heartburn, appetite, nausea, vomiting, vomiting of blood, Indigestion, frequency of bowel movements, change in bowel habits, rectal bleeding, black tarry stools, constipation, abdominal pain, food intolerance, excessive belching or passing of gas, diarrhea, hemorrhoids; jaundice, liver or gall bladder trouble, hepatitis

Urinary: frequency of urination, blood urine, painful urination, urgency, hesitancy, how many times do you get up to urinate at night?_____ incontinence; urinary infections, stone

Genito-reproductive:

Male: discharge from or sore on penis, history of venereal disease, hernias, testicular pain or masses; sexual difficulties

Female: age when periods started_____ ; date of last period: _____; bleeding between periods or after intercourse, painful periods; menopausal symptoms, age at menopause _____, Number of pregnancies _____,

Musculoskeletal: joint pains or stiffness, arthritis, gout, backache. Muscle pains or cramps. Fibromyalgia, reflex sympathetic dystrophy

Peripheral vascular: cramping in the legs when walking, cramps, varicose veins, blood clots

Neurological: fainting, blackouts, seizures, paralysis, local weakness, numbness, tingling, tremors, memory problems

Psychiatric: nervousness, tension, mood swings, depression, PTSD military, PTSD civilian, bipolar, ADD, drug dependence or addiction; alcohol dependence or addiction, pain management

Endocrine: thyroid trouble, heat or cold intolerance excessive sweating, diabetes, excessive thirst, excessive hunger, excessive urination

Hematologic: anemia, easy bruising or bleeding, blood clots, past transfusions and/or possible reactions to blood products

Infectious diseases: TB, hepatitis, HIV, AIDS, staph infections, MRSA

I have answered this form truthfully and to the best of my ability

Signature: _____