

Today's Date:

Baylor Scott & White Texas Orthopedic Partners

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New Orthopedic Surgery Patient Medical History Form

Patient Name

DOB:

Name of Primary Care Physician:	Are you right or left handed?
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What is your occupation?

What Pharmacy do you use:

List your Medications here: (Please include strength and dosage)

Please list all Allergies Here:

Problem History Background

What is your main complaint?	What is the date of your injury? How long has this complaint been present? Months Years
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Please indicate your current pain level 0 1 2 3 4 5 6 7 8 9 10	What makes your pain better ? Rest Heat Cold Medication Exercise Other _____
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What words best describe how the pain feels? Sharp Burning Shooting Deep Stabbing Throbbing Aching Pressure Dull Tingling Other _____	What makes your pain worse ? Rest Heat Cold Medication Exercise Other _____
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Treatment History:

Have you ever been treated by another physician? YES NO

If Yes who: _____

Have you had surgery intended to treat your current complaint? YES NO

If Yes, What type of surgery? _____

Have you had X-Rays, MRI, CT scan or other Radiologic Imaging for this problem? YES NO

If Yes, What type of testing? _____

Have you had an Electromyography or EMG/NCV test to evaluate nerve function? YES NO

If Yes, who performed? _____

Have you tried Activity Modification? YES NO

If Yes, What did you modify? _____

Have you tried NSAIDS? YES NO

If Yes, What have you tried? _____

Have you gone to Physical Therapy for this complaint? YES NO

If Yes, Which facility did you go to? _____

Have you had any injections for this complaint? YES NO

If Yes, what type of injections did you have? _____

Medical History-

AIDS/HIV	Congestive heart failure	GERD	Multiple sclerosis	Scoliosis
Alcoholism	COPD	Gout	Myocardial infarction	Seizure disorder
Alzheimer's	Coronary artery disease	Hepatitis	Obesity	Sleep apnea
Anemia	Crohn's disease	Hyperlipidemia	Osteoarthritis	Lupus
Angina	Degenerative joint disease	Hypertension	Osteoporosis	Spinal stenosis
Arthritis	Depression	Inflammatory bowel disease	Parkinson disease	Spondyloarthopathy
Asthma	Diabetes	Juvenile rheumatoid arthritis	Peptic ulcer disease	Thyroid disease
Atrial fibrillation	Drug abuse	Kidney disease	Psoriasis	Valvular disease
Enlarged Prostate	DVT	Liver disease	PVD	OTHER:
Cancer	Fibromyalgia	Lyme disease	Renal disease	
Cerebrovascular incident	Gallbladder disease	Migraine headaches	Rheumatoid arthritis	

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Surgical History-

ACL surgery:	Arthroscopy wrist:	Colostomy:	LASIK:	OTHER:
Angioplasty:	Arthroscopy shoulder:	Discectomy:	Meniscus surgery:	
Angio w/stent:	Back surgery:	Gastric bypass:	Muscle biopsy:	
Appendectomy:	CABG:	Hernia repair:	ORIF:	
Arthroscopy ankle:	Cardiac valve replacement:	Hip arthroplasty:	Pacemaker:	
Arthroscopy elbow:	Carpal tunnel release:	Hip replacement:	Small bowel resection:	
Arthroscopy hip:	Cataract extraction:	Knee replacement:	Thyroidectomy:	
Arthroscopy knee:	Cholecystectomy:	Laminectomy:	Tonsillectomy:	

Family History– Please list medical problems of your immediate family such as diabetes, high blood pressure, heart disease, etc.

Relation	Medical Condition	Relation	Medical Condition

<u>Constitutional</u>	<u>Eyes</u>	<u>Gastrointestinal</u>	<u>Endo/Hem/Aller</u>
Chills	Blurred Vision	Heartburn	Easy Bruise/bleed
Weight Loss	Double Vision	Nausea	Environmental Allergies
Malaise/Fatigue	Photophobia (Sensitivity to light)	Vomiting	Polydipsia- (Great feeling of thirst)
Diaphoresis (Excessive Sweating)	Eye Pain	Abdominal Pain	<u>Neurological</u>
Weakness	Eye Discharge	Diarrhea	Dizziness
<u>Skin</u>	Eye Redness	Constipation	Tingling
Rash	<u>Cardiovascular</u>	Blood in Stool	Tremor
Itching	Chest Pain	Melena– (Dark, Sticky stool)	Sensory Change
<u>HENT</u>	Palpitations	<u>Genitourinary</u>	Speech Change
Headaches	Orthopnea	Dysuria– (Painful urination)	Focal Weakness
Hearing Loss	Claudication (cramping pain caused by obstruction in arteries)	Urgency	Seizures
Tinnitus	Leg Swelling	Frequency	LOC– (Loss of Consciousness)
Ear Pain	PND– attacks of shortness of breath and coughing at night)	Hematuria– (Blood in urine)	<u>Psychiatric</u>
Ear Discharge	<u>Respiratory</u>	Flank Pain	Depression
Nosebleeds	Hemoptysis-(Coughing up blood)	<u>Musculoskeletal</u>	Suicidal Ideas
Congestion	Sputum Production– (Excessive mucus)	Myalgias- (Muscle pain)	Substance Abuse
Stridor– (Vibrating Noise when breathing)	Shortness of Breath	Neck Pain	Hallucinations
Sore Throat	Wheezing	Back Pain	Nervous/Anxious
		Joint Pain	Insomnia
		Falls	Memory Loss

I attest that everything stated here is true to the best of my knowledge:

Patient Signature: _____

Date: _____

I have personally reviewed this form with the patient:

Provider Signature: _____

Date: _____