Ortho Nebraska

Date: _____

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Chief Complaint ☐Right ☐Left ☐Bilateral Body Part _____

History of Present Illness (Answer these questions regarding your current problem(s) only.)

What symptoms are you experiencing? How did it happen? _____

_____

How long have you had this problem? What is the date of injury? _____

Check any previous treatment(s) you've had for this problem, if applicable: ☐Anti-inflammatory/NSAIDS ☐Bracing

☐Chiropractor ☐Cold Therapy ☐Injection ☐Physical Therapy ☐Relaxation/Rest ☐None ☐Other _____

Have you had any of the following diagnostic studies for your current problem?

☐CT ☐EMG/NCV ☐Epidural steroid/injection ☐MRI ☐Myelogram ☐X-rays ☐Other _____

If yes, please list where and when _____

Allergies ☐No Known Allergies ☐Yes If yes, please list allergy and indicate reaction:

_____ ☐Anaphylaxis ☐Shortness of Breath ☐Hives ☐Itching ☐Other: _____

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_____ ☐Anaphylaxis ☐Shortness of Breath ☐Hives ☐Itching ☐Other: _____

Medications **Please list all current medications and dosages, or bring current list to your scheduled appointment.**

☐I am currently not taking any medications prescribed or over-the-counter.

Medication	Dose	Frequency

Pharmacy Name & Address/Streets: _____ Phone Number: _____

Social History Do you use any of the following? (check all that apply)

Smoking or Smokeless Tobacco ☐Never ☐Current ☐Former (Date Quit: _____)

Electronic Cigarette/Vaping ☐Never ☐Current ☐Former (Date Quit: _____)

Alcohol ☐Never ☐Current (1-2 times per ☐Week ☐Month ☐Year) ☐Former

Non-prescription, mind-enhancing or performance enhancing drugs (please list): _____

Family History

Anesthesia Problems	☐Father	☐Mother	☐Brother	☐Sister
Cancer	☐Father	☐Mother	☐Brother	☐Sister
Bleeding/Clotting (DVT)	☐Father	☐Mother	☐Brother	☐Sister
Diabetes	☐Father	☐Mother	☐Brother	☐Sister
Gout	☐Father	☐Mother	☐Brother	☐Sister
Heart Disease	☐Father	☐Mother	☐Brother	☐Sister
High Blood Pressure	☐Father	☐Mother	☐Brother	☐Sister
Stroke	☐Father	☐Mother	☐Brother	☐Sister

Procedure History (Please list all)

☐None ☐Appendectomy

☐Heart Bypass: (date) _____ ☐Sinus

☐Tubal Ligation ☐C-Section ☐Hysterectomy

☐Stent Placement: (date) _____ ☐Tubes (Ear)

☐Gall Bladder ☐Pacemaker ☐Tonsils

☐Vasectomy ☐Other

☐Orthopaedic: (procedure & date):

_____

Past Personal Medical History

☐Anxiety	☐Depression	☐HIV	☐Pulmonary Embolism
☐Asthma	☐Diabetes	☐Kidney Disease	☐Reaction to Anesthesia
☐Blood Clots/DVT	☐Fibromyalgia	☐Liver Disease	☐Sleep Apnea/C-PAP
☐Blood Disorder	☐Gastric Ulcer	☐Lung Disease	☐Staph
☐Cancer	☐Gout	☐MRSA	☐Stroke
☐Cellulitis	☐Heart Disease	☐Multiple Sclerosis	☐Thyroid Disorder
☐Claustrophobia	☐Hepatitis A/B/C (circle one)	☐Osteoarthritis	☐Other _____
☐Dementia	☐High Blood Pressure	☐Osteoporosis	☐Other _____

Immunizations

Influenza Vaccine	☐Yes (if yes, when? _____)	☐No	☐Unknown
Pneumococcal Vaccine	☐Yes (if yes, when? _____)	☐No	☐Unknown
COVID-19 Vaccine	☐Yes (if yes, ☐Series started ☐Series ended)	☐No	☐Unknown

Patient/Guardian Signature: _____ **Date:** _____