Ortho Nebraska Clinics

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 _____

On a scale of 0-10, how severe is your pain? (0 = no pain present, 10 = worst pain of your life) _____

Pain Description: ☐Aching ☐Burning ☐Dull ☐Numbness ☐Pressure ☐Sharp ☐Shooting ☐Throbbing ☐Tingling ☐Unable to Describe ☐Other _____

Do any of the following activities make it worse? (Check all that apply)

☐Activities of Daily Living ☐Exercise ☐Lifting ☐Lying Down ☐Rising from a Chair ☐Sitting ☐Standing ☐Walking ☐Other _____

Allergies to Medications, X-Ray Dye, Metals and/or Soaps

☐ No Known Allergies ☐ Yes (please list and indicate reaction): _____

_____

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: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

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): _____

Do you exercise regularly? ☐Yes ☐No How many times per week? ☐Daily ☐1-2 ☐3-4 ☐5-6

What kind of work do you do? _____

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 past procedures)

☐ None ☐ Orthopaedic: (procedure & date) _____

☐ Appendectomy	☐ Heart Bypass: (date) _____	☐ Sinus	☐ Tubal Ligation
☐ C-Section	☐ Hysterectomy	☐ Stent Placement: (date) _____	☐ Tubes (Ear)
☐ Gall Bladder	☐ Pacemaker	☐ Tonsils	☐ Vasectomy

Other: _____

Past 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 _____

Review of Systems (Please mark current systems)

Constitutional
☐ Normal ☐ Obesity
☐ Chills ☐ Weight Change
☐ Fever
☐ Night Sweats

HEENT
☐ Normal ☐ Visual Problems
☐ Headache
☐ Hearing Loss
☐ Tooth Pain

Respiratory
☐ Normal
☐ Shortness of Breath

Cardiovascular
☐ Normal
☐ Chest Pain
☐ Difficulty Breathing

Gastrointestinal
☐ Normal ☐ Vomiting
☐ Heartburn/Acid Reflux
☐ Nausea

Genitourinary
☐ Normal
☐ Urinary Frequency
☐ Urinary Incontinence

Hema/Lymph
☐ Normal ☐ Bruises Easy
☐ Bleeds Easy

Endocrine
☐ Normal ☐ Excessive Thirst
☐ Excessive Sweating

Immunologic
☐ Normal ☐ Swollen Neck Glands
☐ Seasonal Allergies

Musculoskeletal
☐ Normal
☐ Other Joint Pain

Integumentary
☐ Normal
☐ Rash
☐ Skin Lesions

Neurologic
☐ Normal ☐ Tingling
☐ Motor Disturbances ☐ Vertigo/Dizziness
☐ Numbness

Psychiatric
☐ Normal ☐ Depression
☐ Anxiety

Health Promotion

Have you been discharged from a nursing facility, hospital or skilled rehabilitation facility in the last 30 days? ☐ Yes ☐ No

If you are 64 years of age or older, please answer the below questions:

Advanced Care Planning

Do you have an Advance Directive?	☐ Yes	☐ No
Are you providing a copy of your Advance Directive at your visit?	☐ Yes	☐ No
Are you interested in receiving additional information on Advance Directives?	☐ Yes	☐ No

Fall Prevention

Are you non-ambulatory (wheelchair bound or bedridden)?	☐ Yes	☐ No
Have you Fallen in the past year?	☐ Yes	☐ No
If yes, how many times? _____		
If yes, were you injured?	☐ Yes	☐ No
Do you feel unsteady standing or walking?	☐ Yes	☐ No
Do you worry about falling?	☐ Yes	☐ No

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