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? _____

Is this a Workman's Comp case? ☐Yes ☐No Is this related to an auto accident? ☐Yes ☐No

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 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): _____

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

If you are employed, what is your occupation? _____

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

Past Medical History

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

Procedure History (Please list all past procedures)

☐ None ☐ Orthopaedic: (procedure & date) _____

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

Other: _____

Review of Systems (Please mark current systems)

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

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

Respiratory
- ☐ Normal
- ☐ Shortness of Breath

Cardiovascular
- ☐ Normal
- ☐ Chest Pain
- ☐ Difficulty Breathing

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

Genitourinary
- ☐ Normal
- ☐ Urinary Frequency
- ☐ Urinary Incontinence

Hema/Lymph
- ☐ Normal
- ☐ Bleeds Easy
- ☐ Bruises Easy

Endocrine
- ☐ Normal
- ☐ Excessive Sweating
- ☐ Excessive Thirst

Immunologic
- ☐ Normal
- ☐ Seasonal Allergies
- ☐ Swollen Neck Glands

Musculoskeletal
- ☐ Normal
- ☐ Other Joint Pain

Integumentary
- ☐ Normal
- ☐ Rash
- ☐ Skin Lesions

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

Psychiatric
- ☐ Normal
- ☐ Anxiety
- ☐ Depression

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 _____, ended _____)	☐ No	☐ Unknown

Health Promotion

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:** _____