Ortho Nebraska Clinics

Date: _____

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Referred By: (First) _____ (Last) _____

Primary Physician: (First) _____ (Last) _____

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 sports related injury? ☐ Yes ☐ No If yes, name the school/club: _____

Is this a result of an auto accident? ☐ Yes ☐ No Date of Injury: _____

Is this a Workers' Compensation case? ☐ Yes ☐ No Date of Injury: _____

Do you have an attorney assisting you? ☐ Yes ☐ No

Is there any legal action pending? ☐ Yes ☐ No

Check any previous treatment(s) you've had for this problem, if applicable: ☐ Anti-inflammatory/NSAIDS ☐ Bracing ☐ Chiropractor ☐ Cold Therapy ☐ Emergency Room ☐ Injection ☐ Medication ☐ Physical Therapy ☐ Relaxation/Rest ☐ Repositioning ☐ Surgery ☐ None ☐ Other _____

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

☐ CT	Where: _____	When: _____
☐ EMG/NCV	Where: _____	When: _____
☐ Epidural steroid/injection	Where: _____	When: _____
☐ MRI	Where: _____	When: _____
☐ Myelogram	Where: _____	When: _____
☐ X-rays	Where: _____	When: _____
☐ Other	Where: _____	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 Tobacco ☐ Never ☐ Current ☐ Former (Date Quit: _____)

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

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

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

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

Employer: _____ ☐ Retired ☐ Disabled ☐ Unemployed

What kind of work do you do? _____

Are you a student? ☐ Yes ☐ No If yes, please list your grade and school name: _____

Family History (Please check where applicable)

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 (Check all that apply)

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

Procedure History (Please list all past procedures)

☐ None

☐ Orthopaedic: (procedure & date) _____

☐ Stent Placement: (date) _____ ☐ Heart Bypass: (date) _____

☐ Pacemaker ☐ Hysterectomy ☐ Appendectomy ☐ Gall Bladder ☐ Sinus

☐ C-Section ☐ Tubal Ligation ☐ Tonsils ☐ Tubes (Ear) ☐ Vasectomy

☐ Other: _____

Review of Systems (Please mark current systems)

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

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

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:** _____

OFFICE USE

☐ Fall Education Offered ☐ Reviewed/Entered By _____
☐ Advance Directive Information Provided