Ortho Nebraska

Date: _____

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____

**Chief Complaint** ☐Right ☐Left ☐Bilateral Body Part _____ Shoe Size (if for foot/ankle) _____

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

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

_____

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

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

From 0-10, how severe is your pain? (0 = no pain present, 10 = worst pain of your life) 0 1 2 3 4 5 6 7 8 9 10

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

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

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

_____ ☐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, neither prescribed or nor 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, (Date Quit: _____ )

Non-prescription, mind-enhancing or performance enhancing drugs _____

**Family History**

| | | | | |
|---|---|---|---|---|
| Anesthesia Problems | ☐Father | ☐Mother | ☐Brother | ☐Sister |
| Cancer | ☐Father | ☐Mother | ☐Brother | ☐Sister |
| Blood clots (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**

| | Date (month/yr) |
|---|---|
| ☐None | |
| ☐Heart Bypass | _____ |
| ☐Stent Placement | _____ |
| ☐Pacemaker | _____ |
| ☐Other _____ | _____ |
| ☐Orthopaedic Procedures: | |
| _____ | _____ |
| _____ | _____ |

**Past Personal Medical History**

| | | | |
|---|---|---|---|
| ☐Anxiety | ☐Dementia | ☐Hepatitis A/B/C | ☐Sleep Apnea/C-PAP |
| ☐Asthma | ☐Depression | ☐High Blood Pressure | ☐Staph |
| ☐Blood Clots/DVT/PE | ☐Diabetes | ☐HIV | ☐Stroke |
| ☐Blood Disorder | ☐Fibromyalgia | ☐Kidney Disease | ☐Thyroid Disorder |
| ☐Cancer | ☐Gastric Ulcer | ☐Liver Disease | ☐Other _____ |
| ☐Cardiomyopathy | ☐Gout | ☐Lung Disease | **Reaction to Anesthesia** |
| ☐Cellulitis | ☐Heart Arrhythmias | ☐MRSA | ☐Malignant Hyperthermia |
| ☐Claustrophobia | ☐Heart Attack (MI) | ☐Multiple Sclerosis | ☐Nausea and/or vomiting |
| ☐Congenital Heart Disease | ☐Heart Failure | ☐Osteoarthritis | ☐Slow to wake |
| ☐Coronary Artery Disease | ☐Heart Valve Disease | ☐Osteoporosis | ☐Pseudocholinesterase Deficiency |

COVID-19 Vaccine ☐Series started ☐Series completed ☐Unknown ☐Declined

Influenza (Flu) Vaccine ☐Received during current flu season ☐Not received during current flu season ☐Unknown

Pneumococcal Vaccine ☐Received less than 5 years ago ☐Received more 5 years ago ☐Not received ☐Unknown

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