Banner Health®

NEW PATIENT MEDICAL HISTORY
ORTHOPEDIC SPECIALTY

Patient Name: ______________________________ **Date of Birth:** ______________

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): ______________________________

Primary Care Provider

Name: ______________________________ Phone #: ______________

Address: ______________________________ Fax #: ______________

What is the primary reason for your visit? ______________________________

Date of onset of problem or injury: ______________________________

Did you bring X-Rays / CT / MRI today? ❑ Yes ❑ No

Is this a work related injury? ❑ Yes ❑ No If yes, will you be using workman's comp benefits? ❑ Yes ❑ No

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.** ❑ No Known Allergies

Allergy:	Reaction:

Do you have any known allergies to metal? ❑ Yes ❑ No If yes, explain: ______________________________

MEDICATIONS

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

❑ Not taking any medications

Medication Name:	Dose:	How often?

MEDICAL HISTORY

List all medical conditions you are being treated for (high blood pressure, etc.)

1.	**4.**
2.	**5.**
3.	**6.**

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Have you had any recent hospitalizations or ER visits (provide dates and reason below)?
❑ No prior hospitalizations/ER visits

Date:	

SURGICAL HISTORY

List all prior surgeries and the date. ❑ No prior surgeries

Date	Type of Surgery	Date	Type of Surgery

Have you had any difficulty with anesthesia? ❑ Yes ❑ No If yes, explain: ____________________

Have you received any blood transfusions in the past? ❑ Yes ❑ No Any problems? ❑ Yes ❑ No

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brothers				
Sisters				

SOCIAL HISTORY

Occupation ____________________ Employer ____________________

Exercise? No ____ Yes ____ Type(s) ____________________ Hours per Week ________

Do you have advance directives? ____________________

Do you have any religious belief that could affect your medical care? ____________________

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Tobacco/smoking status: Never _____

Current _____ Type __________ Amount __________ Duration __________

Former _____ Type __________ Amount __________ Duration __________

Do you use alcohol? No _____ Yes _____ Type __________ Amount __________ Frequency __________

Do you use Caffeine? No _____ Yes _____ Type __________ Amount __________ Frequency __________

Do you use recreational drugs? No _____ Yes _____ Type __________ Amount __________ Frequency __________

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(03/2017)

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PAIN ASSESSMENT

When did symptoms begin: _____/_____/______

Location of pain/symptoms: ______________________

Severity of Pain (0=min, 10=max): _________________

Pain Frequency: (mark all that apply)
❑ Rare ❑ Occasional ❑ Constant
❑ Stairs only ❑ Stairs and walking

Status:
❑ Worse ❑ Stable ❑ Improving ❑ Resolved

Radiation of pain:
❑ No ❑ Yes, radiates to: ______________________

Quality of pain: (mark all that apply)
❑ Aching ❑ Burning ❑ Dull
❑ Piercing ❑ Sharp ❑ Throbbing
Other: ____

Injury/Trauma? ❑ No ❑ Yes
If Yes, when/where? (work, school, vacation, automobile, other):
____

Aggravated by: (mark all that apply)
❑ Bending ❑ Lifting ❑ Sitting
❑ Climbing stairs ❑ Movement ❑ Standing
❑ Descending stairs ❑ Pushing ❑ Walking
❑ Nothing
Other: ____

Prior treatment: (mark all that apply)
❑ Brace/splint ❑ Ice ❑ Mobility
❑ Elevation ❑ Injection ❑ Stretching
❑ Exercise ❑ Massage ❑ Physical Therapy
❑ Heat ❑ Rest ❑ Nother
❑ OTC/prescription meds: ______________________
Other: ____

Did any of the prior treatments above give relief?
If so, please circle.

Which is your dominant hand? Right / Left

Associated symptoms: (mark all that apply)
❑ Bruising ❑ Limping
❑ Spasms ❑ Pain after inactivity
❑ "Crunching" ❑ Locking
❑ Swelling ❑ Stiffness
❑ Decreased mobility ❑ Wake at night
❑ Tingling in arms ❑ Tingling in legs
❑ Pain at night ❑ Difficulty going to sleep
❑ Joint feels unstable ❑ Numbness
❑ Weakness ❑ Joint tenderness
❑ "Popping" Other: ____________________________
____

Functional Abilities: Can you...

Get in/out of car	❑ Yes	❑ No	❑ With difficulty
Kneel	❑ Yes	❑ No	❑ With difficulty
Put on sock/shoes	❑ Yes	❑ No	❑ With difficulty
Go down stairs	❑ Yes	❑ No	❑ With a rail
Go up stairs	❑ Yes	❑ No	❑ With a rail
Sit in chair	❑ 1 hr.	❑ 30 min.	❑ Difficult
Walking distance:	❑ indoors		❑ <5 blocks
	❑ 5-10 blocks		❑ >10 blocks

Do you have a limp?
❑ None ❑ Slight ❑ Moderate ❑ Severe

I require a…
❑ Cane ❑ Crutches
❑ Walker ❑ Wheelchair ❑ None

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REVIEW OF SYSTEMS

In the last **thirty days,** have you experienced any of the following:

CONSTITUTIONAL			GASTROINTESTINAL			PSYCHIATRIC		
Chills	Yes	No	Abdominal pain	Yes	No	Anxiety	Yes	No
Fatigue/Weakness	Yes	No	Constipation	Yes	No	Depression	Yes	No
Fever	Yes	No	Black tarry stools	Yes	No	Insomnia	Yes	No
Malaise/Discomfort	Yes	No	Diarrhea	Yes	No	**SKIN**		
Night sweats	Yes	No	Heartburn or reflux	Yes	No	Contact allergy	Yes	No
Weight gain	Yes	No	Jaundice	Yes	No	Itchy skin	Yes	No
Weight loss	Yes	No	Loss of appetite	Yes	No	Rash	Yes	No
HEENT			Nausea	Yes	No	Skin infections/sores	Yes	No
Blurred/Double vision	Yes	No	Vomiting	Yes	No	Poor wound healing	Yes	No
Difficulty swallowing	Yes	No	Ulcers, GI bleeding	Yes	No	**HEMATOLOGIC**		
Ear drainage	Yes	No	Hepatitis Type: ______	Yes	No	Anemia Type: ______	Yes	No
Facial pain	Yes	No						
Headache	Yes	No	**GENITOURINARY**			Bleeding tendencies	Yes	No
Hearing loss	Yes	No	Pain with urination	Yes	No	Bruising	Yes	No
Hoarseness	Yes	No	Frequent urination	Yes	No	Blood clots	Yes	No
Nasal Congestion	Yes	No	Blood in urine	Yes	No	**IMMUNOLOGICAL**		
Ringing in ears	Yes	No	Urinary incontinence	Yes	No	Bee sting allergies	Yes	No
Vertigo/Dizziness	Yes	No	Urinary tract infections	Yes	No	Cancer Type: ______	Yes	No
Vision loss	Yes	No	Prostate enlargement	Yes	No			
Glaucoma	Yes	No	Problem passing a bladder catheter or urination after surgery	Yes	No	Contact dermatitis	Yes	No
RESPIRATORY			**METABOLIC/ENDOCRINE**			Environmental allergies	Yes	No
Chest pain	Yes	No	Cold intolerance	Yes	No	Food allergies	Yes	No
Cough	Yes	No	Hair loss	Yes	No	Seasonal allergies	Yes	No
Shortness of breath	Yes	No	Heat intolerance	Yes	No	Arthritis Type: ______	Yes	No
Recent infections	Yes	No	Diabetes Type: ______	Yes	No			
TB exposure	Yes	No				AIDS/HIV	Yes	No
Wheezing	Yes	No	Thyroid problems	Yes	No	Metal allergies	Yes	No
COPD	Yes	No	**NEUROLOGICAL**					
Asthma	Yes	No	Difficulty walking	Yes	No			
Emphysema, bronchitis	Yes	No	Dizziness	Yes	No			
CARDIOVASCULAR			Poor coordination	Yes	No			
Chest pain	Yes	No	Memory loss	Yes	No			
Cyanosis	Yes	No	Muscle weakness	Yes	No			
Heart murmur	Yes	No	Numbness, tingling	Yes	No			
Leg swelling	Yes	No	Seizures	Yes	No			
Syncope (fainting)	Yes	No	Tremors	Yes	No			
Irregular heartbeat	Yes	No	Stroke, TIA, Paralysis	Yes	No			
Heart attack	Yes	No						
Congestive heart failure	Yes	No						
Heart catheterization	Yes	No						

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