

Name _____ Appt. Date _____ Dr. _____

DOB _____ ***** PLEASE FILL OUT BOTH SIDES OF FORMS! *****

Medical History

If you have pain: Describe it. (Constant, Intermittent, Dull, Sharp, Aching, Burning, Shooting, Etc.) _____

If you have a shooting pain, does it travel on one side more than the other? Yes ____ No ____

If **Yes**, which side, **Right** or **Left**? (circle one)

Rate the pain on a scale of Zero to Ten (**Zero** is no pain, **Ten** is worst pain ever) _____

What makes your symptoms **worse**? (i.e. – activity, being on your feet, walking, etc.) _____

What makes your symptoms **better**? (i.e. – rest, elevation, etc.) _____

Have you had a **similar problem before**? Yes ____ No ____

Have you had any of the following orthopedic problems before? (circle Yes or No)

- Joint Swelling Yes / No
- Neck/Back Pain Yes / No
- Ruptured Disc Yes / No
- Torn Cartilage-Knee Yes / No
- Bone/Joint Infection Yes / No
- Dislocated Joints Yes / No
- Osteoporosis (brittle bones) Yes / No
- Scoliosis Yes / No
- Amputations Yes / No
- Fractures Yes / No
- Sciatica Yes / No

Have you had a blood transfusion? Yes / No
What year(s)? _____

Have you ever had an infection in an incision after surgery?
 Yes / No **List:** _____

Have you ever had problems with anesthesia? Yes / No
List: _____

Have you or a family member ever had a bleeding problem after surgery? Yes / No **List:** _____

Are you **Right** or **Left** handed? (circle one)

Any previous surgeries? Yes ____ No ____ **If yes, please list the surgery and the date / year you had it:**

Please check the following?

YOURSELF

Yes No

RELATIVE

Yes No

WHO?

- Blood Clots _____
- Cancer _____
- Diabetes _____
- High blood pressure _____
- Heart disease _____
- Lung disease _____ Your Cardiologist's Name
- Epilepsy _____
- Severe Arthritis _____
- Ulcers _____
- Gout _____
- Kidney disease _____
- Infectious diseases / HIV..... _____
- Liver Disease or Hepatitis _____

Social History (Circle Yes or No)

- Currently drink alcohol Yes / No
- Currently use street drugs Yes / No
- Used street drugs in the past Yes / No
- Currently smoking Yes / No
- Smoked in the past Yes / No

I hereby authorize payment directly to Johnson County Orthopedics from the above-named insurance company(s), and the release of information on this form (parts 1 & 2) by Johnson County Orthopedics to the same.

X _____

Signed (Patient, Parent or Guardian) ~***OVER***~

Reviewed by: _____ Date: _____ Code: _____
 Reviewed by: _____ Date: _____ Code: _____
 Reviewed by: _____ Date: _____ Code: _____
 Reviewed by: _____ Date: _____ Code: _____

REVIEW OF SYSTEMS

Have you ever had any of the following:

- | | | |
|--------------------------|--------------------------|---|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. CONSTITUTIONAL |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent weight loss |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. EYES |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent change in vision |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. EARS, NOSE, MOUTH, THROAT |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent ear infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent sore throats |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent sinus infections |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. CARDIOVASCULAR |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains or discomfort in chest |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. RESPIRATORY (Circle those that apply) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, bronchitis, pneumonia, pleurisy, or TB |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. GASTROINTESTINAL |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent indigestion or heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Passing bloody or black stools |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. GENITO-URINARY |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| | | MALE |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in testicles |
| | | FEMALE |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal vaginal bleeding |
| | | Last menstrual period _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. MUSCULOSKELETAL |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent fractures or sprains |
| <input type="checkbox"/> | <input type="checkbox"/> | History of arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. INTEGUMENTARY |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent changes in skin |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. NEUROLOGICAL |
| <input type="checkbox"/> | <input type="checkbox"/> | History of frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures or convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. PSYCHIATRIC |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment for psychiatric problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment for drug or alcohol dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. ENDOCRINE |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased energy |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. HEMATOLOGIC / LYMPHATIC |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising or bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. ALLERGIC / IMMUNOLOGIC |
| <input type="checkbox"/> | <input type="checkbox"/> | Severe allergic reactions to: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever |