**The Orthopedic and Sports Medicine Center of Oregon**

**Medical History**

NAME: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEIGHT: ft. in. WEIGHT: lbs. GENDER: MALE FEMALE

PRIMARY CARE PHYSICIAN: PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: MARITAL STATUS: # CHILDREN

***THIS INFORMATION IS VITAL IN THE AUTHORIZATION AND CLEARANCE PROCESS***

***FOR ANY IMAGING, DIAGNOSTIC AND/OR SURGICAL PLANNING***

DESCRIBE THE REASON FOR VISIT:

WHEN DID THIS EPISODE OF SYMPTOMS BEGIN?

SCALE OF 1-10 (10 is most severe) circle the # that best describes your pain:1 2 3 4 5 6 7 8 9 10

**CIRCLE ALL THAT APPLY**: pain stiffness swelling instability weakness locking numbness

ARE SYMPTOMS: constant intermittent worsening improving unchanged

RESULTING FROM: sports accident work related injury motor vehicle accident

WHAT MAKES SYMPTOMS WORSE?

WHAT MAKES SYMPTOMS BETTER?

HAND DOMINANCE (circle one): LEFT RIGHT

**List any treatments that you have had for this problem below:**

MEDICATIONS: DATE STARTED:

THERAPY: DATE STARTED:

INJECTIONS: DATE STARTED:

IMAGING:(MRI/CT/XRAY) LOCATION: WHEN:

**Allergies (including reaction) to Medications, X-ray Dyes or other Substances** NONE

**DO YOU HAVE OR USE ANY OF THE FOLLOWING:** NONE

|  |  |  |
| --- | --- | --- |
| * Implants | * Pacemaker | * CPAP |
| * Stent / Shunt | * Nerve Stimulator | * Loose or removable teeth |

**REVIEW OF SYSTEMS Please check if you have history of any of the following:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***GENERAL*** |  | *CARDIOVASCULAR* |  | ***HEMATOLOGIC*** |  |
| Pregnant or Nursing |  | Chest Pain / Angina |  | Anemia |  |
| Diabetes I or II ? A1C? \_\_\_\_\_\_\_ |  | Heart Attack |  | Blood Clots |  |
| MRSA |  | Myocardial Infarction |  | Bleeding Tendency |  |
| Kidney Disease |  | Palpitations |  | Easily Bruised |  |
| Stomach or intestinal problems |  | High Blood Pressure |  | Circulatory Problems |  |
| Asthma or Lung Disease |  | Shortness of breath |  | Currently on Blood Thinners |  |
| Cancer Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Swelling of lower extremities |  | Type? |  |
| Fatigue |  | Sleep Apnea |  | Phlebitis |  |
| Weakness |  | **NEUROLOGICAL** |  | ***MUSCULOSKELETAL*** |  |
| Fevers |  | Headaches |  | Joint pain |  |
| Skin disorders: Type?\_\_\_\_\_\_\_\_\_ |  | Dizziness/Fainting |  | Joint swelling |  |
| Rheumatic Fever |  | Stroke |  | Muscle weakness |  |
| Tuberculosis |  | Memory Loss |  | Muscle tenderness |  |
| Recent weight gain/loss |  | Muscle Spasms |  | Morning stiffness |  |
| Recent cold or flu |  | Numbness/Tingling of hands or feet |  | Arthritis / Osteoarthritis  Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Depression |  | Blindness or Trouble Seeing |  |
| Anxiety |  | Deafness or Trouble Hearing |  | Rheumatoid Arthritis |  |
| ***INFECTION*** |  | Seizures |  | Osteoporosis |  |
| Dental |  | ***BLOODBORN PATHOGENS*** |  | Gout |  |
| Urinary |  | HIV / AIDS |  | Bone or joint infections |  |
| Other: |  | Hepatitis |  | Fractures |  |

**FAMILY HISTORY**

**Please check the following if any family member has a history of the condition listed:**

* Diabetes
* Heart Disease
* Anesthetic Complications
* Bleeding Disorder
* Rheumatoid Arthritis
* Gout
* OSTEOARTHRITIS
* REACTION to ANESTHESIA
* Blood Clots
* CANCER TYPE(s):

HAVE YOU HAD ANY PREVIOUS FRACTURES? Yes No

Which body part(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY**

Have you or a family member had a bad reaction to anesthesia? Yes No

|  |  |
| --- | --- |
| TYPE OF OPERATION: | YEAR: |
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|  |  |
|  |  |
|  | |

**Current Medications, Supplements and Over-The-Counter Medications** NONE

|  |  |  |
| --- | --- | --- |
| MEDICATION | REASON | FREQUENCY |
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| --- | --- | --- |
| Current tobacco smoker? YES NO  Packs per day \_\_\_\_\_\_\_  Smokeless tobacco? YES NO  Former tobacco smoker? YES NO  Year quit? \_\_\_\_\_\_\_\_  Never smoker? YES NO | | Do you consume alcohol? YES NO  History of abuse? YES NO  Drinks per week: \_\_\_\_\_\_\_\_\_\_\_\_  Recreational drug use? YES NO  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| List sports and hobbies are you involved in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Patient Signature:**  I, as the patient, state the information is correct and accurate to the best of my knowledge. | **Physician Signature:** | |