

TENNESSEE VALLEY BONE and JOINT

2350 North Ocoee St. • Cleveland, TN 37311
office 423.476.5554 • toll-free 877.676.5554 • fax 423.614.6116

Date: ___/___/2018

ORTHOPEDIC PATIENT HISTORY

Name: _____ Date of Birth: _____ Age: _____ Referring Physician: _____

Chief Complaint: What is your main reason for being seen today? Is the area of concern on the right, left, or both sides of your body? _____

Is this complaint due to an injury? Yes No Date of injury? ___/___/___ What state did the injury occur in? _____

Listed below are possible ways of describing your typical pain. Please check all of the descriptions that apply to your primary pain.

Throbbing Shooting Stabbing Sharp Cramping Aching Burning

How often do you experience your pain? Constant Comes and goes Good days and bad days

Place an **X** on the line below to indicate how severe your pain is:

No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Pain Imaginable

Past Medical History: Do you, or have you had any of the following medical problems?

Asthma COPD Depression Heart Disease HIV/AIDS Migraines
 Cancer Diabetes Congestive Heart Failure GI Bleed Arthritis Gastric Reflux
 Hepatitis Stroke High Blood Pressure High Cholesterol Heart Attack Liver disease
 Fibromyalgia Seizure Kidney Problems/failure Thyroid Disease Blood Clots Glaucoma

Any medical problems not listed: _____

Past Surgical History: Please list any surgeries you have had: _____

Females: (circle one) Are you pregnant or is there any chance that you may be pregnant? Yes No

Do you have any metal clips, plates, or pins in your body? No Yes Explain: _____

Are you claustrophobic or do you have difficulty with enclosed spaces? _____

Medications: Please list all medications you are currently taking: _____

Allergies: Do you have any drug allergies? No Please list: _____

Do you receive pain medication from any other provider? Yes No If YES then who: _____

Social History: Do you engage in the following: Smoke ___ Alcohol ___ Use drugs
Marital Status: Single Married Separated Divorced Widowed
Employment: Homemaker Part-time Full-time Unemployed
Education: High School Some College College Grad. Post-Graduate
Occupation: _____

Family History: Has your father, mother, or sibling had any of the following? (Please check all that apply)

___ Accidental Death ___ Adopted ___ Alzheimer Disease ___ Cancer ___ Diabetes ___ Hypertension
___ Heart Attack ___ Kidney Disease ___ Liver Disease ___ Lung Problems ___ Unaware of Medical History
Father Living Deceased Mother Living Deceased

Patient Signature: _____ Date: _____

REVIEW OF SYSTEMS – TO BE FILLED OUT BY PATIENT

Cardiovascular:

- Stroke
- Circulatory Problems
- Heart Attack
- High Blood Pressure
- Chest Pain
- Pacemaker

Respiratory:

- Difficulty Breathing
- Asthma/wheezing
- Cough
- Pulmonary Emboli

Gastrointestinal:

- Stomach Ulcers
- Active Healed
- GERD/Acid Reflux
- Recent change in Bowel Habits

Bleeding Profile:

- Anemia
- Blood Disorders
- Liver Disease
- Family History of Liver Disease

Genitourinary:

- Difficulty Voiding
- Painful Urination
- Blood in Urine
- Frequency

Neuro-Muscular:

- Joint Pain
- Treated for Arthritis
- Muscle Weakness

Endocrine:

- Thirst Change
- Appetite Change
- Diabetes
- Chronic Steroid Use

Eyes, Ears, Nose & Throat:

- Glaucoma
- Blurred Vision
- Loss of Vision
- Glasses Contacts
- Ringing in Ears
- Hearing Loss
- Difficulty Swallowing
- Sinus / Nose Bleeds

Constitutional:

- Fever/chills
- Dizziness
- Hot Flashes
- Recent Illness
- Weight Change

Allergy:

- Seafood
- X-ray dye
- Seasonal Allergies
- Other _____

TO BE FILLED OUT BY THE PROVIDER

VITAL SIGNS

Temp: _____ Blood Pressure: _____ Heart Rate: _____ Height: _____ Weight: _____

OFFICE NOTES

Provider Signature: _____ Date: _____