Omaha Orthopedic Clinic & Sports Medicine

Patient Information **Date:**_______________

Name: ______________________	Date of Injury: ______________
Birthdate: ______________ Age: ______	Onset of Problem (Approximate Date): ______________
Primary Care Physician: ______________	Have you seen a physician for today's problem?
Referred by: ______________________	☐yes ☐no Who? ______________
Workman's Comp: ☐yes ☐no ______________	**HAVE YOU HAD ANY OF THE FOLLOWING TESTS?**
Accident: ☐yes ☐no ______________ _	☐CAT Scan ☐X-ray ☐Bone Scan ☐MRI ☐ EMG
	If done obtained where? ______________
☐right handed ☐left handed	Other Specify:______________

Chief Complaint/Location of Injury/Briefly describe current problem

Past Medical History (Check all that apply or check here if none apply, overall healthy: ☐

☐ Alzheimers	☐ Diabetes	☐ Hypothyroidism	☐ Parkinson's disease
☐ Angina	☐ Diverticulitis	☐ Hypoglycemia	☐ Polymyalgi/Fibromyalgia
☐ Anemia	☐ Emphysema	☐ Irritable bowel syndrome	☐ Pneumonia
☐ Anxiety	☐ Esophageal Reflux	☐ Liver disease	☐ Pulmonary Infection
☐ Asthma	☐ Gastritis	☐ Lumbar disc disease	☐ Rheumatoid Arthritis
☐ Arrhythmia	☐ Glaucoma	☐ Lupus	☐ Seizures
☐ Osteoarthritis	☐ Gout	☐ Malignant Hyperthermia	☐ Sleep apnea
☐ Bleeding Disorder	☐ Headaches	☐ Malignant Hypothermia	☐ Strokes/CVA
☐ Blood Clots/DVT	☐ Hepatitis	☐ MRSA	☐ Ulcers/Acid Reflux/Gerd
☐ Cholelithiasis	☐ HIV	☐ Multiple sclerosis	☐ Vascular Problems/Circ
☐ Colitis	☐ High Cholesterol	☐ Myocardial infarction	☐ Varicose Veins
☐ Cardiac Problems	☐ Hyperthyroidism	☐ Obesity	☐ Vertigo
☐ Cancer (Specify)	☐ High Blood Pressure	☐ Osteoporosis	

Other:____

Surgical History (Check all that apply) Problems with Anesthesia ☐yes ☐no

☐ AAA repair	☐ Colon resection	☐ **Orthopedic Surgery**	☐ Back Surgery
☐ AICD	☐ Fundoplication	☐ ACL Reconstruction	☐ Ankle Replacement **L R**
☐ Appendectomy	☐ Gastric bypass	☐ Arthroscopy (specify)	☐ Carpal Tunnel Rel **L R**
☐ Artificial Heart Valve	☐ Hernia	☐ Ankle **L R**	☐ Hip replacement **L R**
☐ Breast surgery	☐ Hysterectomy	☐ Elbow **L R**	☐ Knee replacement **L R**
☐ CABG	☐ Implanted Defibrillator	☐ Hip **L R**	☐ Shoulder Replacement **L R**
☐ Carotid endarterectomy	☐ Lung Surgery	☐ Knee **L R**	
☐ Cataract extraction	☐ Pacemaker	☐ Shoulder **L R**	
☐ Cesarian Section	☐ Prostate Surgery	☐ Wrist **L R**	
☐ Cholecystectomy	☐ Tonsillectomy		

Other:____

Physician Use Only: Height__________ **Weight**__________ **BP** __________ **Pulse**__________

Name:______________________________ Date:_________________

Medications: ☐yes ☐no List:	**Allergies:** ☐yes ☐no
____	____
____	____
____	____
____	**LATEX ALLERGY** ☐yes ☐no
____	Problem with adhesive bandaids? ☐yes ☐no
____	
____	

Family Medical History
(Check Problem and who was diagnosed: Mother=**M**, Father=**F**, Sister=**S**, Brother=**B**

Problem	Who	Problem	Who
☐ High Blood Pressure	☐M ☐F ☐S ☐B	☐ Cancer **Specify:**	
☐ Stroke	☐M ☐F ☐S ☐B		
☐ Heart Disease	☐M ☐F ☐S ☐B	______________________________	☐M ☐F ☐S ☐B
☐ Diabetes	☐M ☐F ☐S ☐B	______________________________	☐M ☐F ☐S ☐B
☐ Gout	☐M ☐F ☐S ☐B	______________________________	☐M ☐F ☐S ☐B
☐ Arthritis	☐M ☐F ☐S ☐B	______________________________	☐M ☐F ☐S ☐B
☐ Seizures	☐M ☐F ☐S ☐B	______________________________	☐M ☐F ☐S ☐B

Other: ____

Social History:

☐Single ☐Married ☐Widowed ☐Divorced

Number of Children:______________________________

Female only: Are you pregnant? ☐yes ☐no

Occupation:______________________________________

Recreation:______________________________________

Do you drink Alcohol: ☐yes ☐no	Years smoked: ______
No. Drinks: ☐1 ☐2 ☐3 ☐4 ☐5+	Previously smoked: ☐yes ☐no
Frequency: ☐day ☐week ☐mo	Length of time since quit: ______
Type: ☐beer ☐wine ☐mixed drink	Do you chew tobacco: ☐yes ☐no
Do you smoke?: ☐yes ☐no	Drug use: ☐yes ☐no
Packs/day: ☐1/4 ☐1/2 ☐1 ☐1-2+	Specify:__________________________
	__________________________________

Name: _______________________________ Date:______________________

Review of Systems: (Please indicate yes or no. If yes please circle the specific item and add other items as needed.)

CONSTITUTIONAL	Fever Fatigue Weight gain Weight loss	Other: ______________	Yes	No
EYES	Blurred vision Vision loss Eye pain	Other: ______________	Yes	No
ENT	Hearing loss Sinus problems Ear discharge	Other: ______________	Yes	No
CARDIOVASCULAR	Heart defects Palpitations Shortness of Breath Murmurs Skipping heartbeat Chest Pain	Other: ______________	Yes	No
RESPIRATORY	Difficult breathing Chronic cough Pneumonia Tuberculosis TB exposure	Other: ______________	Yes	No
GASTROINESTINAL	Nausea Vomiting Diarrhea Constipation Blood in stool Appetite loss Ulcers	Other: ______________	Yes	No
GENITOURINARY	Urinary Infections Frequency Incontinence	Other: ______________	Yes	No
HEMATOLOGIC	Blood clots Bleeding	Other: ______________	Yes	No
MUSCULOSKELETAL	Joint pain Back pain Muscle cramps Swelling Numbness Stiffness Tingling sensation Arthritis	Other: ______________	Yes	No
SKIN	Skin rash Itching Infections Lesions Ulcers	Other: ______________	Yes	No
NEUROLOGICAL	Memory loss Seizures Dizzy Spells Stroke/TIA Paralysis Severe headaches	Other: ______________	Yes	No
PSYCHIATRIC	Depression Anxiety Memory loss	Other: ______________	Yes	No
ENDOCRINE	Thyroid problem Diabetes	Other: ______________	Yes	No
	Diabetes If yes, are you Insulin dependent		Yes	No
LYMPHATIC	Abnormal bruising Bleeding disorders HIV	Other: ______________	Yes	No

This document was reviewed on the above date by: ____