Newport Orthopedics
A Lifespan Physician Group Practice
Delivering health with care®

INITIAL HISTORY SURVEY

Patient Name (please print):_____Date:_____Provider:_____

Chart #_____

Age_____ ☐ F ☐ M Height_____/_____ Weight _____

BP_____/_____ Pulse_____
Temp._____ H____/____ W_____

Who requested that you visit our office?

☐ Doctor Name:_____ ☐ Attorney_____

Are you right-handed or left-handed? _____

✹ What is the main reason for your visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other_____(chief complaint)

✹ What body part is involved? (Location)						
☐ Neck	☐ Shoulder (R) ☐ Shoulder (L)	☐ Elbow (R) ☐ Elbow (L)	☐ Hand (R) ☐ Hand (L)	☐ Pelvis (R) ☐ Pelvis (L)	☐ Knee (R) ☐ Knee (L)	☐ Foot (R) ☐ Foot (L)
☐ Back (Mid) ☐ Back (Lower)	☐ Arm (R) ☐ Arm (L)	☐ Wrist (R) ☐ Wrist (L)	☐ Finger (R) ☐ Finger (L)	☐ Hip (R) ☐ Hip (L)	☐ Ankle (R) ☐ Ankle (L)	☐ Toe (R) ☐ Toe (L)

How long has this problem been present? _____ ☐ Days ☐ Weeks ☐ Months

Check the box which best fits <u>how your problem started</u>. Then answer the one question below the box you check.

☐ **NO INJURY** (**Onset was**: ☐ Gradual or ☐ Sudden)
Why do you think it started?

☐ **INJURY – (Accident or Sport NOT Auto or Work)**
Date_____ Where and How did it happen?
What sport? _____ School _____

☐ **INJURY AT WORK**
Date_____ Where and How did it happen?

☐ **WORK RELATED – (BUT <u>NO</u> INJURY)**
Date_____ How did your job cause this problem?

☐ **AUTO ACCIDENT** Date_____ How was your car hit?

ANSWER:
_____
_____
_____
_____
_____

WORK STATUS
Are you able to work? ☐ Yes or ☐ No
If NO – WHY?_____
If YES – ☐ Light or ☐ Full Duty?
Do you require a work note today ☐ Yes or ☐ No

Please check the box below which best describes your problem:
✹ The pain is ☐ Constant ☐ Comes and goes (Intermittent)
✹ **<u>Severity</u>** of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe
✹ What is the **<u>quality</u>** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____
Are there **<u>associated symptoms</u>**? ☐ Swelling ☐ Numbness ☐ Weakness
Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged
Does your pain wake you from sleep? ☐ Yes ☐ No
What makes your symptoms **<u>worse</u>**? ☐ Activity ☐ Exercise ☐ Work ☐ Other_____
What makes you feel **<u>better</u>**? ☐ Rest ☐ Heat ☐ Ice ☐Elevation ☐ Other_____
What medications have you take or been prescribed for this problem? _____
Check which treatments you have tried? Injection ☐Y ☐N Brace ☐Y ☐N Therapy ☐Y ☐N Cane/Crutch ☐ Y ☐N

✹ *Minimum dictation required for New/Consult Level 3, 4, 5 or Established Level 3, 4, 5*

OVER ⟶

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

1. **M/S** ▪ Have you had a **prior** problem with this same Orthopedic condition in the past? ☐ Yes ☐ No (explain)

   _____

   ▪ Have you had prior ☐ Back Pain ☐ Joint Swelling ☐ Prior Fracture ☐ Arthritis _____

2. **GI** ▪ Do you have stomach ulcers ☐Y ☐N, Blood in Stool, ☐Y ☐N, Stomach pain w/anti-inflammatory pills ☐Y ☐N

3. **HEM** ▪ Are you taking, or have you ever taken **BLOOD THINNERS**? (i.e., Coumadin, Plavix, aspirin) ☐Y ☐N Type?_____

   ▪ Do you suffer from any of the following? ☐ Easy bleeding ☐ Easy bruising ☐ Anemia ☐ None

4. **ARE YOU DIABETIC**? ☐ Y ☐N **TREATMENT:** ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

(Please check any that apply, or mark None)	NONE	YEAR	Explain Details/Comments
5. CON ☐Weight loss ☐Loss of appetite ☐Fever ☐Cancer	☐	____	_____
6. EYE ☐Glasses ☐Contacts ☐Double vision ☐Cataracts	☐	____	_____
7. ENT ☐Hearing loss ☐Hoarseness ☐Ringing in ears	☐	____	_____
8. CV ☐High Blood Pressure ☐Heart Attack ☐Blood Clots	☐	____	_____
9. RS ☐Asthma ☐Cough ☐Pneumonia ☐Short of Breath ☐TB	☐	____	_____
10. GU ☐Pain with Urination ☐Blood in Urine ☐Kidney Disease	☐	____	_____
11. SK ☐Skin Ulcers ☐Rash ☐Lumps	☐	____	_____
12. NEU ☐Seizures ☐Stroke ☐Balance Problem ☐Headaches	☐	____	_____
13. PSY ☐Depression ☐Nervousness ☐Sleep Disorder	☐	____	_____

PAST MEDICAL HISTORY

✹ What Medications do you take? ☐ None Please list with dosage: _____

_____

_____

Are you allergic to any medications? ☐Y ☐N If yes, please list: _____

Past Hospitalizations (Not for surgery) ☐ None _____

Past Surgical History: What operations have you had? When? ☐ None _____

Do you have a history of substance abuse? ☐Y ☐N If yes, explain_____

Have you had a Transplant? ☐Y ☐N If yes, organ and date of surgery_____

Any complications with Anesthesia? ☐Y ☐N If yes, explain_____

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relatives?

✹ Any direct relative with the same Orthopedic condition you are being seen for today? ☐Y ☐N _____

Diabetes ☐Y ☐N _____ High Blood Pressure ☐Y ☐N_____ Heart Disease ☐Y ☐N_____ Arthritis ☐Y ☐N _____

SOCIAL HISTORY:

✹ Do you use tobacco? ☐Y ☐N **Packs per day**____ Alcohol use? ☐Y ☐N How often? ☐Daily ☐Other ____/week

Marital History: M S D W How many people live with you?_____

Are you currently working? ☐Y ☐N If no, how long have you been off work? _____

Occupation: _____ ☐Student Employer: _____

FOR OFFICE USE ONLY

Reviewed by MD _____ Date_____/_____/_____