



# CENTRAL CAROLINA ORTHOPAEDIC ASSOCIATES, PLLC

P.O. BOX 3247 • SANFORD, NC 27331-3247

919.774.1355 • 1.866.649.8435 • 919.774.3395 FAX

## ORTHOPAEDIC NEW PATIENT HISTORY

Patient's Last name	First name	Today's Date / /	Family Physician
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Patient's Age	Date of Inquiry or when problem started / /	Right or Left Handed?
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What is the reason for seeking orthopaedic care? \_\_\_\_\_

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Have any tests been performed? (MRI / CT scan / Bone scan / nerve tests / bone density / etc.) \_\_\_\_\_

Location of test \_\_\_\_\_

IF WORK RELATED: Employer \_\_\_\_\_ Current job \_\_\_\_\_

Are you working now?  Yes  No  Regular Duty  Light Duty  
 Did you have an accident at work?  Yes  No  
 Is there modified work available?  Yes  No

Did your pain start at work?  Yes  No  
 Is your injury or pain due to the work you do?  Yes  No  
 Do you have an attorney for this?  Yes  No

Name of attorney \_\_\_\_\_

**SOCIAL HISTORY**       Student  Single       Married       Divorced/Separated       Widowed

What is your occupation? \_\_\_\_\_

How much alcohol do you drink? Amount each day: \_\_\_\_\_

How much do you smoke? Packs per day: \_\_\_\_\_ Snuff/Dip? \_\_\_\_\_

Any history of addiction to drugs?  Yes  No       Pills       Marijuana       IV drugs       Alcohol       In recovery (how long) \_\_\_\_\_

Are you on disability? Medical/Psychological? \_\_\_\_\_

## ORTHOPAEDIC REVIEW OF SYSTEMS

### Constitutional

- Chills
- Fatigue
- Fever
- Malaise
- Night sweats
- Weakness

### HEENT

- Blurred vision
- Double vision
- Dysphagia
- Ear drainage
- Facial pain
- Headache
- Hearing loss
- Hoarseness
- Nasal congestion
- Ringing in ears
- Vertigo
- Vision loss

### Respiratory

- Chest pain (respiratory)
- Cough
- Dyspnea
- Recent infections
- Known TB exposure
- Wheezing

### Cardiovascular

- Chest pain
- Cyanosis
- Heart murmur
- Irregular heartbeat/palpitations
- Leg swelling
- Syncope

### Gastrointestinal

- Abdominal pain
- Constipation
- Black/tarry stool
- Diarrhea
- Heartburn
- Jaundice
- Loss of appetite
- Nausea
- Vomiting

### Genitourinary

- Dysuria
- Frequent urination
- Hematuria
- Nocturia
- Urge incontinence
- Urinary incontinence

### Integumentary

- Breast lump
- Contact allergy
- Itchy skin
- Rash
- Skin infections
- Skin lesions

### Neurological

- Bladder problems
- Bowel dysfunction
- Difficulty walking
- Memory loss
- Peresthesia
- Seizures
- Tremors
- Weakness

### Musculoskeletal

- Back pain
- Neck pain
- Leg pain
- Low back pain
- Joint fluid
- Joint stiffness

### Metabolic/Endocrine

- Cold intolerant
- Hair loss
- Heat intolerant
- Polydipsia
- Polyuria

### Psychiatric

- Anxiety
- Depression
- Insomnia

### Hematological

- Bleeding
- Bruising
- Easy bruising
- Anemia

### Immunological

- Asthma
- Contact dermatitis
- Environmental allergies
- Food allergies
- Frequent infections, colds
- Seasonal allergies

**MEDICAL HISTORY** Have you ever had any of the following:

- Cancer, Radiation, Chemotherapy
- HIV/AIDS
- Hepatitis (A, B, C)
- Diabetes (Insulin I / no insulin II)
- Asthma/COPD/Bronchitis
- Tuberculosis (treated / not treated)
- Hyperthyroidism, Hypothyroid
- Females (under 50) LMP: \_\_\_\_\_
- Are you pregnant?  Yes  No
- Have you ever had a bone density test  Yes  No
- Osteoporosis
- Blood clot (arms/legs/lungs/brain)
  - Treated
- Bleeding problems/blood disorders
- Neuropathy (Diabetes, spinal, trauma)
- Peripheral vascular disease
- Aortic Aneurysm
- Lupus
- Kidney disease
- Sickle Cell Anemia
- Ulcer (treated/untreated)
- High blood pressure (treated, medication, diet)
- Stroke (Dementia/Alzheimer's)
- Heart Disease/Heart Attack (m
- Other \_\_\_\_\_  
Raynoud's, scheleroderma, rheumatoid, etc.

**SURGICAL HISTORY** What operations / surgeries / procedures have you had?

Please give dates:

\_\_\_\_\_  
\_\_\_\_\_

What broken bones have you had? \_\_\_\_\_

**FAMILY HISTORY** Do your immediate relatives have any of the following conditions?

- Cancer
- Arthritis
- Kidney Disease
- Diabetes
- Stroke
- Tuberculosis
- COPD
- Bleeding problems
- Blood clots
- Hemophilia
- Sickle Cell Anemia
- Alzheimer's/Organic Brain Syndrome
- Heart Disease
- Other \_\_\_\_\_

What medications/other things are you allergic to? \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient's Signature Date / /

**OFFICE USE ONLY**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ Temp \_\_\_\_\_