Tuality Orthopedics

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Welcome to our clinic. In order to provide you with the best care possible, we need to ask you about various aspects of your health history. We ask these questions to all of our clients, so some of them may not apply to you. If you feel uncertain about a question, please feel free to leave it blank.

Name _____ Age _____ DOB_____ Date _____

Primary Care Provider _____ Who referred you to our clinic? _____

Are you □ Right or □ Left handed? Is this a work injury? □ Yes □ No

Reason for visit _____affected side □ Right □ Left

How long have you been experiencing these symptoms?_____

Have you tried physical therapy for this condition in the past? □ Yes □ No

Have you had an MRI done for this condition? □ Yes □ No If yes please list where_____

Have you tried any injection for this condition? □ Yes □ No

Do you have any special questions or concerns today? If so, please describe _____

_____

MEDICAL HISTORY

Please check any of the following categories if you have ever had problems with:

□ Autoimmune Disorder/Lupus/Rheumatoid
□ Peripheral vascular Occlusive Disease
□ Coronary Artery Disease/Heart Disease/Heart attack
□ Stroke
□Gastro Esophageal Reflux Disease/Ulcers
□ Thyroid Disorder
□ Diabetes Type 1 ___ Type 2 ___ Last HgbA1c____
□ DVT (Deep vein thrombosis)
□ High Blood Pressure
□ Cancer what kind? _____
□ High Cholesterol
□ Lung Disease
□Gout
□ Back/Neck Problems
□ Irregular Heartbeat/Atrial Fibrillation
□ Arthritis
□Kidney Disease
□ Asthma
□Hep A, B or C
□ **Have you ever had a Pulmonary Embolism □ Yes □ No**

Other: _____

MEDICAL HISTORY (Continued)

*** Do you take a blood thinner (e.g. aspirin, Coumadin)?** □ **Yes** □ **No**

*** Have you ever had a blood clot?** □ **Yes** □ **No**
*** Have you ever had problems with Anesthesia** □ **Yes** □ **No**
*** Do you have an Advance Directive?** □ **Yes** □ **No**
If yes, Location _____

PAST SURGICAL HISTORY

List any surgeries and include dates:

Arthroscopy: _____
Bowel Surgery: _____
Joint Replacement: _____
Hernia Repair: _____
Appendix Removal: _____
Gallbladder Removal: _____
Heart Surgery: _____
Hysterectomy: _____
Lung Surgery: _____
Tonsillectomy: _____
Other _____

MEDICATIONS

Do you currently take any medications? □ Yes □ No
Please list: name, dose, frequency (e.g. Aspirin 81mg 1x/day). Please including all over the counter medications, prescriptions, and herbal/vitamins.

_____
_____
_____
_____
_____
_____

Medication Allergies and Reactions:

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

□ Married □ Single □ Widowed □ Domestic Partner

* Who do you live at home with? _____

Occupation _____

Disabled □ Yes □ No If yes, Reason for disability _____

Do you smoke or use tobacco products? □ Yes □ No Circle: Oral, pipe, e-cig, cigar, cigarette, chew

If yes, how many packs of cigarettes' per day? _____ How long? _____

Any current use of recreational drugs? □ Yes □ No If yes, Type: _____

Do you use medical Marijuana? □ Yes □ No

How much alcohol do you drink (#drinks/week: Beer/wine/liquor)?

0 _____ 1-5 _____ 6-10 _____ 11-20 _____ ›20 _____

FAMILY HISTORY

Does anyone in your ***immediate*** family have: (Mother, Father, Siblings)

Autoimmune Disorders (Lupus/Rheumatoid/Thyroid): _____

Diabetes: _____

High Blood Pressure: _____

Heart Disease: _____

Arthritis: _____

Blood Clots: _____

Cancer: _____

Other: _____

□ **None of these**	□ Diarrhea	□ Fever	□ Severe headache
□ Cough	□ Rash	□ Red Eye	
□ Muscle pain	□ Weakness	□ Bruising or bleeding	
□ Vomiting	□ Abdominal pain	□ Joint pain	

Constitution: □ Fever □ Chills □ Weight Loss □ Fatigue □ Sweating □ Weakness	**Cardiovascular:** □ Chest pain □ Palpitations □ Shortness of breath when lying flat □ Leg cramping (claudication) □ Leg Swelling □ Paroxysmal nocturnal dyspnea (sleep apnea)	**Musculoskeletal:** □ Muscle Pain □ Neck Pain □ Back Pain □ Joint Pain □ Falls
Skin: □ Rash □ Itching	**Respiratory:** □ Cough □ Coughing up Blood □ Sputum Production □ Shortness of Breath □ Wheezing	**Endocrine/Heme/Allergies** □ Easy Bruising □ Allergies □ Excessive Thirst
Hearing/Nose/Throat: □ Hearing Loss □ Ringing In Ears □ Ear Pain □ Ear Discharge □ Nosebleeds □ Congestion □ Sinus Pain □ Harsh sound in ears □ Sore Throat	**Gastrointestinal:** □ Heartburn □ Nausea □ Vomiting □ Abdominal Pain □ Diarrhea □ Constipation □ Blood In Stool	**Neurological:** □ Dizziness □ Headaches □ Tingling □ Tremors □ Sensory change □ Speech Change □ Localized Weakness □ Seizures □ Loss of Consciousness
Eyes: □ Blurred Vision □ Double Vision □ Light Sensitivity □ Eye Pain □ Eye Discharge □ Eye Redness	**Genitourinary:** □ Painful/Difficult Urination □ Urinary Urgency □ Urinary Frequency □ Blood in Urine □ Flank Pain	**Psychiatric:** □ Depression □ Suicidal ideas □ Substance abuse □ Hallucinations □ Nervous/Anxious □ Insomnia □ Memory loss