Orthopaedic Specialists of Scottsdale

Patient Medical History – Lower Extremity

Last Name: ______________________________ First Name: _____________________________ MI: ________

Date of Birth: ________________ Age: _______ Occupation: _________________________ Retired? ☐Yes ☐No

Primary Care Doctor: ___________________________ Who referred you to our office? ________________________

What are you being seen for today? ____

Have you seen a doctor for this problem before? ☐Yes ☐No If yes, who? ________________________________

When did your current problem begin to cause you symptoms? ____

Did a specific injury or accident start your symptoms? ☐Yes ☐No Is Injury Work-Related? ☐Yes ☐No

If Yes, when was the injury/accident and how did it occur? ____

Are you currently involved in an accident or disability litigation/legal action? ☐Yes ☐No

Were images taken? (X-ray or MRI) ☐Yes ☐No If yes, where? ____

On a scale of 0 – 10, (0 meaning no pain and 10 meaning the worst pain imaginable) how severe is your pain?

Most of the time: ____________________________________
When the pain is the worst: __________________________
When the pain is the least: __________________________

Has your pain recently: ☐ Worsened ☐ Not changed ☐ Improved ☐ Gone away

Does your pain localize to a specific area? ☐ Yes ☐ No If yes, where? _____________________________________

Describe the type of pain symptoms you experience (check all that apply):

☐ Sharp/stabbing ☐ Throbbing ☐ Shooting ☐ Aching ☐ Cramping ☐ Stiffness

☐ Burning ☐ Tingling ☐ Numbness ☐ Dull

Do you experience any of the following symptoms? (check all that apply):

☐ Swelling ☐ Bruising ☐ Locking ☐ Catching ☐ Limping

☐ Joint Instability ☐ Weakness ☐ Poor Balance

Describe when your pain occurs (check all that apply):

☐ Worse in the morning ☐ Worse during the middle of the day ☐ Worse at the end of the day

☐ Keeps or wakes me up at night ☐ Does not vary significantly during the day

When did you first start treating your pain? ☐ <1 month ☐ 1-3 months ☐ 3-6 months ☐ >6 months

What have you done to try and relieve your pain?

☐Stretching exercises ☐Strengthening exercises ☐Weight loss ☐Used brace ☐Pain management

Have you taken any medicines for your pain?

☐ Tylenol ☐ NSAID's ☐ Narcotic pain pills ☐ Glucosamine/Chondroitin/MSM-type supplements

Have you had any prescribed treatment for your pain?

☐ Physical Therapy ☐ Cortisone injections ☐ Lubricating injections (Synvisc, Supartz, Euflexxa)

☐ Other injections: PRP or Stem cells ☐ Other: ______________________________

Pain is made **worse** by (check all that apply):

☐ Standing ☐ Walking ☐ Running ☐ Climbing ☐ Going up stairs ☐ Going downstairs

☐ Bending ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Driving ☐ Exercise

Pain is made **better** by (check all that apply):

☐ Walking ☐ Standing ☐ Exercise ☐ Sitting ☐ Resting ☐ Lying down

☐ Heat ☐ Ice ☐ Nothing in particular makes the pain better

Please describe any limitations in your activity caused by your pain or other symptoms:

I start to feel pain after I walk: ________ yards / miles
I can walk no more than: ________ yards / miles
I can stand no longer than: ________ min / hours at a time
I cannot sit for longer than: ________ min / hours at a time

It is difficult for me to: ☐ Put my socks and/or shoes on ☐ Go up-stairs ☐ Go down-stairs.

Do you use a ☐cane, ☐crutches, or a ☐walker? ☐Yes ☐No If yes, please check which one.

Please list all operations you have had (name and date):

____
____

How often do you exercise? ☐ Daily ☐ 1-2d/wk ☐ 3-4d/wk ☐ >5 d/wk

What types of exercise do you usually do? ______________________________

Do you smoke or chew tobacco? (please circle) ☐ No ☐ Yes If yes, how much and for how long? ____________

Have you used tobacco in the past? ☐ No ☐ Yes If yes, when did you quit? ______________________

How many alcoholic beverages do you have in a day? ______________ A week? ____________________

Have you ever used or currently use illegal IV drugs? ☐ No ☐ Yes If yes, please explain: ______________

Have you had or now have any infectious diseases such as MRSA infection, Hepatitis, Tuberculosis, HIV/AIDS?

☐ No ☐ Yes If so, please list: ____

What diseases, if any, are common in your family? (i.e. diabetes, heart attacks, cancer, etc.)

________________ ________________ ________________ ________________

Height: __________ Weight: ___________

ALLERGIES: (Drugs, Foods, etc.)	REACTIONS/Side Effects

Patient name: ______________________________ Date of Birth: _______________

Medication Information

Please list all medications you currently take, including Prescriptions, Over-the-Counter, Patches, Inhalers, Vitamins, Herbal Supplements and Eye drops.

DRUG NAME	DOSE	ROUTE e.g. oral, injectable, inhaled	FREQUENCY	REASON for TAKING

Review of Systems

In the **past month** have you experienced any of the following problems? Please CHECK all that apply:

☐ Infections	☐ Sore throat	☐ Nausea/vomiting	☐ Sore joints
☐ Fever	☐ Cough	☐ Constipation/diarrhea	☐ Muscle aches
☐ Chills	☐ Swollen glands	☐ Abdominal pain	☐ Poor sleep
☐ Night sweats	☐ Shortness of breath	☐ Ulcers	☐ Skin rash
☐ Fatigue	☐ Chest pain	☐ Kidney/bladder problems	☐ Depression
☐ Weight loss	☐ Fainting	☐ Urination problems	☐ Anxiety
☐ Weight gain	☐ Swollen feet	☐ Bleeding problems	☐ Headaches

Other: ________________________________

☐ **I have had none of the above problems**

Patient name: ____ Date of Birth: ______________

Please indicate any and all medical conditions for which you have been treated:

	Under active treatment	Been treated in the Past
Heart disease	______________	______________
Heart attack	______________	______________
Congestive heart failure	______________	______________
Irregular heartbeat	______________	______________
Hypertension (High blood pressure)	______________	______________
Diabetes	______________	______________
Blood clots in your legs	______________	______________
Blood clots in your lungs	______________	______________
Stroke	______________	______________
Osteoporosis (weak bones)	______________	______________
Bleeding problems	______________	______________
Anemia	______________	______________
COPD/Emphysema/Bronchitis (circle)	______________	______________
Sleep Apnea	______________	______________
Stomach/Intestinal Ulcer	______________	______________
Gastritis/Reflux disease (circle)	______________	______________
Leukemia/Lymphoma (circle)	______________	______________
Thyroid disease	______________	______________
Liver disease	______________	______________
Hepatitis	______________	______________
Cirrhosis	______________	______________
Kidney disease	______________	______________
Bladder infection	______________	______________
Prostate difficulty	______________	______________
Severe body aches	______________	______________
Fibromyalgia	______________	______________
MRSA infection	______________	______________
Dental infections or loose teeth	______________	______________
HIV/AIDS	______________	______________
Depression	______________	______________
Poor circulation	______________	______________
Rheumatoid Arthritis	______________	______________

Other ____

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature: ______________________________________ Date: ____________________

Printed Name: ____________________________________ Date of Birth: _____________

*At ORTHOPAEDIC SPECIALISTS OF SCOTTSDALE, we assure you that the above information is part of your personal and private medical record. As such, it will not be shared with anyone outside this office without your specific, written permission, except for circumstances wherein we are required to do so by law.