Banner Health

NEW PATIENT MEDICAL HISTORY
ORTHOPEDIC SPECIALTY

Patient Name: ______________________ **Date of Birth:** ______________

Gender Identity (Optional) ______________________

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): ______________________

Primary Care Provider

Name: ______________________ Phone #: ______________

Address: ______________________ Fax #: ______________

What is the primary reason for your visit? ______________________

Date of onset of problem or injury: ______________________

Did you bring X-Rays / CT / MRI today? ❑ Yes ❑ No

Is this a work related injury? ❑ Yes ❑ No If yes, will you be using workman's comp benefits? ❑ Yes ❑ No

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.**

❑ No Known Allergies

Allergy:	Reaction:

Do you have any known allergies to metal? ❑ Yes ❑ No If yes, explain: ______________________

MEDICATIONS

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

❑ Not taking any medications

Medication Name:	Dose:	How often?

MEDICAL HISTORY

List all medical conditions you are being treated for (high blood pressure, etc.)

1.	**4.**
2.	**5.**
3.	**6.**

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9999-0123
(02/2021)

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Patient Name: ______________________________ **Date of Birth:** ____________________

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?
❑ No prior hospitalizations/ER visits

Date:	

SURGICAL HISTORY

List all prior surgeries and the date. ❑ No prior surgeries

Date	Type of Surgery	Date	Type of Surgery

Have you had any difficulty with anesthesia? ❑ Yes ❑ No If yes, explain: ____________________
Have you received any blood transfusions in the past? ❑ Yes ❑ No Any problems? ❑ Yes ❑ No

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brothers				
Sisters				

SOCIAL HISTORY

Occupation ______________________________ Employer ______________________________
Exercise? No ____ Yes ____ Type(s) ______________________________ Hours per Week __________
Do you have advance directives? ______________________________
Do you have any religious belief that could affect your medical care? ______________________________

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Tobacco/smoking status: Never _____
Current _____ Type ______________ Amount ______________ Duration ______________
Former _____ Type ______________ Amount ______________ Duration ______________
Do you use alcohol? No _____ Yes _____ Type __________ Amount ______________ Frequency ______________
Do you use Caffeine? No _____ Yes _____ Type __________ Amount ______________ Frequency ______________
Do you use recreational drugs? No _____ Yes _____ Type __________ Amount __________ Frequency ______________

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PAIN ASSESSMENT

Have you had any previous problems in this area? Yes/No

Location of pain/symptoms: ____________________

Please rate the stability of the affected area:

0 = no instability, 10 = very unstable: ____________

Severity of Pain right now (0 = min, 10 = max): ________

Pain at rest: 0 = Min, 10 = Max ________

Pain with activity: 0 = Min, 10 = Max ________

Pain Frequency: (mark all that apply)
❑ Rare ❑ Occasional ❑ Constant
❑ Stairs only ❑ Stairs and walking

Status:
❑ Worse ❑ Stable ❑ Improving ❑ Resolved

Radiation of pain:
❑ No ❑ Yes, radiates to: ____________________

Quality of pain: (mark all that apply)
❑ Aching ❑ Burning ❑ Dull
❑ Piercing ❑ Sharp ❑ Throbbing
Other: ______________________________

Injury/Trauma? ❑ No ❑ Yes
If Yes, when/where? (work, school, vacation, automobile, other):

____

Aggravated by: (mark all that apply)
❑ Bending ❑ Lifting ❑ Sitting
❑ Climbing stairs ❑ Movement ❑ Standing
❑ Descending stairs ❑ Pushing ❑ Walking
❑ Nothing
Other: ______________________________

Prior treatment: (mark all that apply)
❑ Brace/splint ❑ Ice ❑ Mobility
❑ Elevation ❑ Injection ❑ Stretching
❑ Exercise ❑ Massage ❑ Physical Therapy
❑ Heat ❑ Rest ❑ Nothing
❑ OTC/prescription meds: ____________________
Other: ______________________________

Did any of the prior treatments above give relief?
If so, please list: ____________________

Which is your dominant hand? Right / Left

Associated symptoms: (mark all that apply)
❑ Bruising ❑ Limping
❑ Spasms ❑ Pain after inactivity
❑ "Crunching" ❑ Locking
❑ Swelling ❑ Stiffness
❑ Decreased mobility ❑ Wake at night
❑ Tingling in arms ❑ Tingling in legs
❑ Pain at night ❑ Difficulty going to sleep
❑ Joint feels unstable ❑ Numbness
❑ Weakness ❑ Joint tenderness
❑ "Popping" Other: ____________________

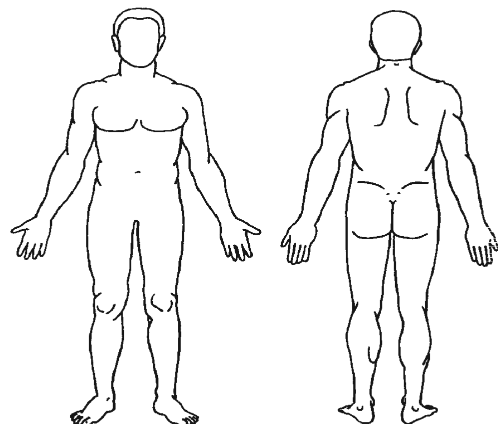
Functional Abilities: Can you...

Get in/out of car	❑ Yes	❑ No	❑ With difficulty
Kneel	❑ Yes	❑ No	❑ With difficulty
Put on sock/shoes	❑ Yes	❑ No	❑ With difficulty
Go down stairs	❑ Yes	❑ No	❑ With a rail
Go up stairs	❑ Yes	❑ No	❑ With a rail
Sit in chair	❑ 1 hr.	❑ 30 min.	❑ Difficult
Walking distance:	❑ indoors		❑ Less than 5 blocks
	❑ 5-10 blocks		❑ Greater than 10 blocks

Do you have a limp?
❑ None ❑ Slight ❑ Moderate ❑ Severe

I require a… ❑ Cane ❑ Crutches
❑ Walker ❑ Wheelchair ❑ None

Indicate on the drawing below where you are having associated symptoms.



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