GOLDEN ORTHOPAEDIC
Knee, Hip, Shoulder & Foot Center
The Center of Excellence for Joint Care

Appointments Call (561) 488-2200

ORTHO NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

YOUR PAST SURGICAL HISTORY

☐ **No Surgical History**

☐ Hip Replacement – RT/LT		☐ Fracture – Type:	
☐ Knee Replacement – RT/LT		☐ Pacemaker	
☐ Shoulder/Rotator Cuff – RT/LT		☐ Open Heart/By-Pass	
☐ Carpal Tunnel – RT/LT		☐ Spine – Type/Level:	
☐ Arthroscopy – Type:		☐ Other:	

Any additional surgical information:

YOUR FAMILY HISTORY

☐ **Family History Unknown**

☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well
☐ Cancer– Type: ____________	☐ Cancer– Type: ____________	☐ Cancer– Type: ____________	☐ Cancer– Type: ____________
☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Other: ____________	☐ Other: ____________	☐ Other: ____________	☐ Other: ____________

YOUR SOCIAL HISTORY

Tobacco Use: ☐ Current ☐ Former ☐ Never
Type: ____________
Packs/Day: ____________
Years Used: ____________
Have you ever tried to quit? ☐ Yes ☐ No

Alcohol Use: ☐ No ☐ Yes ☐ Former
Type: ☐ Beer ☐ Wine ☐ Liquor
Frequency: ____________
Amount per Sitting: ____________
Last Drink: ____________

Caffeine Use: ☐ No ☐ Yes
Type: ☐ Coffee ☐ Tea ☐ Soda ☐ Tablets ☐ Energy Drinks ☐ Chocolate
Daily Amount: ____________

REVIEW OF SYSTEMS

☐ **All Negative Below** **Check if you have any of the following:**

☐ Fever	☐ Heart Murmur	☐ Cold Intolerance	☐ Rash
☐ Weakness	☐ Leg Swelling/Edema	☐ Heat Intolerance	☐ Skin Infections
☐ Weight Gain/Loss (Circle)	☐ Syncope/Fainting		☐ Skin Lesions

	Gastrointestinal (GI)	Neurological	Blood Disorders
☐ Blurred Vision	☐ Constipation	☐ Difficulty Walking	☐ Bleeding
☐ Facial Pain	☐ Diarrhea	☐ Dizziness	☐ Bruising
☐ Headache	☐ Nausea	☐ Poor Coordination	
☐ Vertigo/Dizziness	☐ Vomiting	☐ Muscle Weakness	

Respiratory	Urinary	Psychiatric	Immune System
☐ Dyspnea (Difficulty Breathing)	☐ Dysuria (Difficulty Urinating)	☐ Anxiety	☐ Asthma
☐ Recent Infections	☐ Frequent Urination	☐ Depression	☐ Environmental Allergies
☐ Wheezing	☐ Hematuria (Blood in Urine)	☐ Insomnia	☐ Food Allergies

YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan.

Patient Signature: **Date:** ___ /___ /___

If Minor, Guardian Signature: **Date:** ___ /___ /___

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ORTHO NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date of Visit: ___ /___ /___ **Dr. you are seeing today:** ________________

YOUR INFORMATION

Full Name:

Date of Birth: ___ /___ /_____ **Age:** _____

Height: **Weight:**

Preferred Language:

Email:

Occupation:

Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Disabled ☐ Military

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Life Partner

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Living Status: ☐ Lives Alone ☐ With Spouse ☐ Skilled Nursing ☐ With Other Family - Who:

Primary Care Physician: **Cardiologist (if applicable):**

Who referred you to us? ☐ Physician: ☐ Friend: ☐ Other:

YOUR MEDICATIONS

☐ **No Medications** List all the medications you take, both prescription & nonprescription below:

Are you taking Aspirin or any other blood thinners? ☐ Yes ☐ No

YOUR ALLERGIES

☐ **No Allergies** **Indicate all the allergies you have to medications and/or food & describe reaction below:**
Common reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

____

____

YOUR PHARMACY INFORMATION

Do you have a preferred pharmacy that you use? ☐ Yes ☐ No

Pharmacy Name: **Pharmacy Phone #:**

Street Address: **City/State/ZIP**

YOUR PAST MEDICAL HISTORY

☐ **No Relevant Medical History**

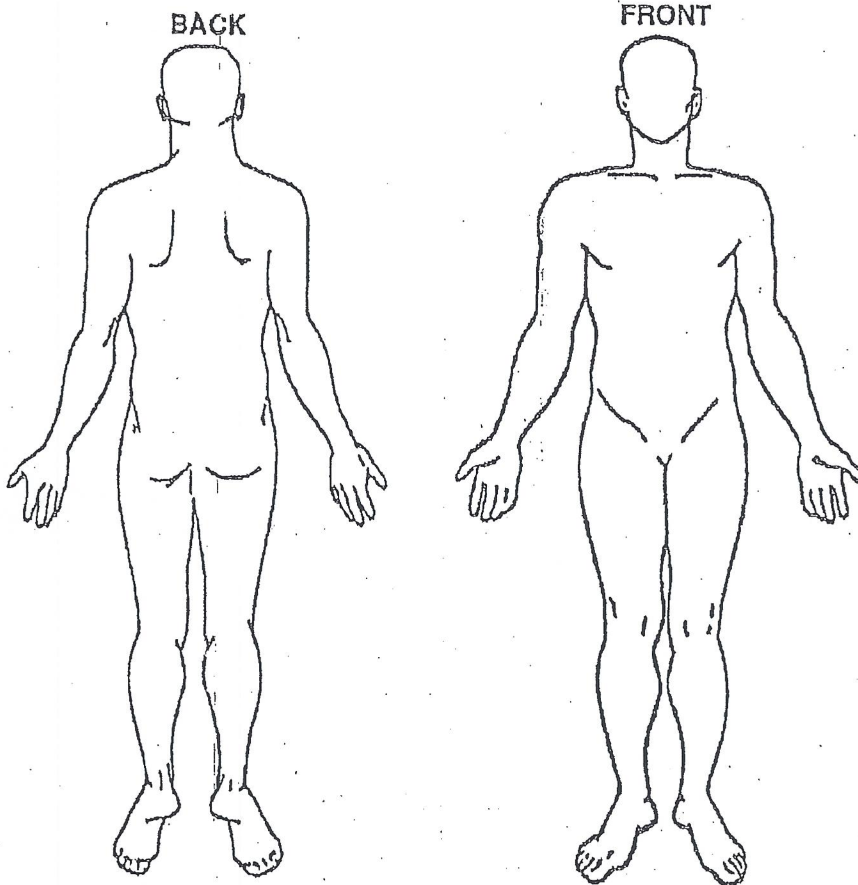
Disease Type:	Date of Onset:	Disease Type:	Date of Onset:
☐ Hypertension	___ /___ / ___	☐ Obesity	___ /___ / ___
☐ Kidney Disease	___ /___ / ___	☐ Peripheral Vascular Disease	___ /___ / ___
☐ Heart Disease: ________	___ /___ / ___	☐ Anxiety	___ /___ / ___
☐ Diabetes – I or II	___ /___ / ___	☐ Depression	___ /___ / ___
☐ Osteoarthritis	___ /___ / ___	☐ Stroke	___ /___ / ___
☐ Osteoporosis	___ /___ / ___	☐ DVT/Blood Clots	___ /___ / ___
☐ Rheumatoid Arthritis	___ /___ / ___	☐ Ulcers	___ /___ / ___
☐ Cancer– Type: ______	___ /___ / ___	☐ AIDS/HIV	___ /___ / ___
			___ /___ / ___
☐ Other: ____________	___ /___ / ___	☐ Other: ____________	

Name: ______________________ Date: ______________

Pain Diagram

Mark the areas on your body where you feel the described sensation. Use the approprlate symbol. Mark areas of radiation. Include all affected areas.

Tingling 0000
Pain XXXX
Numbness IIII



Put a mark through the line below to rate your pain intensity on average
No pain -- worst possible pain

Put a mark through the line below to rate your pain intensity at its worst
No pain -- worst possible pain