

BLUEGRASS ORTHOPAEDICS

PATIENT HISTORY

Please PRINT and fill out completely

Today's Date: _____ Patient# _____ DOB: _____ Account# _____

Name: _____

Age: _____ Height: _____ Weight: _____ Hand Dominance: Left Right

Referring Physician: _____ Primary Care Physician: _____

MEDICATIONS

Please list medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin and any over the counter medications. Include Vitamin, Mineral and herb supplements.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Latex: Yes No Metal Allergies (Earrings): _____ Nickel Allergy

Are you allergic to any medication: Yes No

Please list all medications that you are allergic to: _____

HISTORY OF INJURY:

Did the problem result from a specific injury? Yes No Injury/Accident Date: _____

Did your problems begin following: Work Injury Motor Vehicle Accident What State? _____

How did you get injured? _____

If neither, how long have you had the condition? _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful): _____

Is the Pain: Constant Occasional Sharp Dull Aching Stabbing Throbbing

What symptoms are you experiencing? Locking Catching Giving Way Popping Grinding Other

What, if anything, makes your symptoms *better*? _____

What, if anything, makes your symptoms *worse*? _____

Have you seen another physician for this injury? Yes No

If yes, who? _____

What treatments have you tried for this injury? Nothing Physical Therapy Exercise Acupuncture

Chiropractic injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)

Medications: _____ Other: _____

Patient Name: _____

Practitioner's Initials: _____

Have you ever had the following tests for this injury?

Test	Date (month/year)	What facility? (clinic/hospital)
<input type="checkbox"/> X-Rays	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Blood tests	_____	_____
<input type="checkbox"/> Other	_____	_____

PAST SURGICAL HISTORY

Please check any previous surgical procedures, list the date and describe the surgery:

- Appendectomy Hernia Repair Arthroscopy Gallbladder
- Spine/Back surgery Heart surgery Total joint replacement Previous Fracture
- Other: _____

MEDICAL HISTORY

Please check current or previous medical conditions:

- Anemia Depression Hepatitis A B or C Heart Attack/Stroke
- Arthritis Diabetes High Blood Pressure Rheumatoid
- Asthma Emphysema HIV Thyroid
- Blood Clots Heart Disease Irregular Heartbeat Diverticulitis
- Cancer Liver Disease Osteoporosis Heartburn/Acid Reflux
- Blood Transfusion History of Multiple Fractures
- Other: _____

SOCIAL HISTORY

- Special Diet: Yes No Any Restrictions? _____
- Tobacco Use: Yes No Type: _____ Duration: _____ Quit Date: _____
- Alcohol Use: Yes No Frequency? _____
- Drug Use: Yes No Frequency? _____
- Caffeine Use: Yes No Frequency? _____
- Exercise: Yes No Frequency? _____

FAMILY HISTORY

Please check family history conditions:

- Blood Clots Diabetes Hypertension Rheumatoid Arthritis
- Cancer Heart Disease Osteoporosis Stroke/Seizures

Please describe any immediate family history of medical problems: _____

Patient Name: _____

Practitioner's Initials: _____

REVIEW OF SYMPTOMS

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems, please check in the negative box.

- 1. CONSTITUTIONAL GENERAL None Weight Loss Weight Gain Insomnia Chronic Fatigue
 Other: _____
- 2. EYES None Vision Change Glasses/Contacts Cataracts Glaucoma
 Other: _____
- 3. EARS, NOSE, THROAT None Loss of Hearing Seasonal Allergies Sinus Pain Ringing
 Other: _____
- 4. CARDIOVASCULAR None Chest pain Edema Hypertension Palpitations
 High Cholesterol Other: _____
- 5. RESPIRATORY None Asthma Wheezing Frequent Cough
 Other: _____
- 6. GASTROINTESTINAL None Heartburn Indigestion Acid Reflux Ulcer Problems
 Abdominal Pain Peptic Ulcer GI Stomach Bleed
 Other: _____
- 7. MUSCULOSKELETAL None Arthritis Muscle Weakness Joint Pain Back Pain
 Other: _____
- 8. SKIN None Rash Ulcers Scars
 Other: _____
- 9. NEUROLOGICAL None Headaches Seizures Numbness Dizziness
 Other: _____
- 10. PSYCHIATRIC None Depression Crying Anxiety Mood Swing
 Other: _____
- 11. ENDOCRINE None Diabetes Hypothyroid Hyperthyroid Hot Flashes
 Other: _____
- 12. HEMATOLOGY None Easy Bruising Bleeding Anemia
 Other: _____

Signature: _____

Date: _____

Print Name: _____