Towson Orthopaedic Associates New Patient Medical Questionaire

ACCOUNT NO.:

We appreciate your time and effort spent accurately completing this form. *Date:* ________________

Name: ____ *Age:* _____ *Birthdate:*______

Patient SS#: ________________ *Home Phone:* ______________________ *Work Phone:* ________________

Address: ____

Email: ______________________________ *Is it OK for this office to contact you by email?* Yes No

Referral Source:
☐ Physician ☐ Urgent Care ☐ Family Member ☐ Friend ☐ Patient of TOA ☐ Physical Therapist
☐ Athletic Trainer ☐ Emergency Room: ____________________ ☐ Other: ____________________

Name of Referral Source: ____

Referring Physician: ____________________________Pharmacy:____________________

Primary Care Physician: ____

*Race**: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ More one race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused to Report/Unreported ☐ Undefined

*Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report/Unreported ☐ Undefined

*Preferred Language**: ☐ English ☐ Other ☐ Undefined

Orthopaedic History

What is your chief problem at this time? (☐ left ☐ right) ____________________________________

____

How long has the problem been present? ☐ Days (#:_____) ☐Weeks (#_____) ☐Months (#_____) ☐ Years (#____)
Approximate Date of Onset: ____

Is this problem related to ______work _____Motor Vehicle _____ Liability ______If yes, Date of Injury _______

Past Medical History

Height: ______________ *Weight:* __________

Current Medical Conditions (Please check the boxes that apply to you.)

☐ High Blood Pressure ☐ Heart Problems ☐ High Cholesterol ☐ Diabetes ☐ Circulation Problems
☐ Stomach Ulcers ☐ Acid Reflux Disease ☐ Asthma ☐ Thyroid Problems ☐ Bleeding Problems
☐ Depression ☐ Anxiety

Could you be pregnant? ☐ No ☐ Yes IF ***YES***, DO NOT TAKE X-RAYS; NOTIFY X-RAY TECHNICIAN.

List Prior Surgeries:

Approx Date	Type of Surgery	Approx Date	Type of Surgery
__________	______________________	__________	______________________
__________	______________________	__________	______________________
__________	______________________	__________	______________________

List all medications you are taking (prescriptions, over-the-counter, and/or herbal and nutritional supplements):

________________ ________________ ________________ ________________
________________ ________________ ________________ ________________
________________ ________________ ________________ ________________

Do you have any allergies (ie., certain medications, betadine, iodine, latex, etc.)? ☐No ☐Yes
Please List:____

Do you take any blood thinners (ie., Coumadin, aspirin, etc.)? ☐No ☐Yes
Please List:____

** Newly required information by the U.S. Department of Health and Human Services.*

Social History

Education: ☐ Grade School ☐ High School ☐ College ☐ Graduate School

If you are a student, where do you attend school? ____________________

Current sports participation: ☐ High School ☐ College ☐ Club ☐ Recreational ☐ Professional

Exercise: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise? ____________________

Employment Status: ☐ Student ☐ Unemployed ☐ Work in the home ☐ Retired

☐ Employed (Occupation: ____________________) *Do you live alone?* ☐No ☐Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed *Children* ☐ No ☐Yes #___

Smoke currently: ☐ No ☐ Yes ________ Packs per day for ________ years

Quit smoking: ☐ This year ☐ greater than 1 year ☐ greater than 5 years ☐ greater than 10 years

Previously smoked: ________ packs per day for ________ years

Drink Alcohol: ☐ No ☐ Yes Daily #________ Weekly # ________ Monthly # ________ Yearly # ________

History of substance abuse (drug use, etc.): ☐ No ☐ Yes, List: ____________________

Family Health History (List Family members with medical problems)

	Alive/Deceased/Age	Medical Problems (Heart, Diabetes, etc)		Alive/Deceased/Age	Medical Problems (Heart, Diabetes, etc)
Father	________	________	*Sibling*	________	________
Mother	________	________	*Sibling*	________	________

Review of Systems (Please Check if any previous history)

Constitutional
- *Weight Loss* ☐ No ☐ Yes
- *Weight Gain* ☐ No ☐ Yes

Eyes
- *Corrective Lenses* ☐ No ☐ Yes

Ears, Nose, Throat ☐ No ☐ Yes

Cardiovascular
- *Heart Problems* ☐ No ☐ Yes
- *High Blood Pressure* ☐ No ☐ Yes
- *Circulation Problems* ☐ No ☐ Yes

Respiratory
- *Asthma* ☐ No ☐ Yes
- *Obstructive Pulmonary (COPD)* ☐ No ☐ Yes

Gastrointestinal
- *Acid Reflux* ☐ No ☐ Yes
- *Stomach Ulcers* ☐ No ☐ Yes
- *Liver problems (Hepatitis)* ☐ No ☐ Yes
- *Inflammatory Bowel* ☐ No ☐ Yes

Genitourinary
- *Bladder problems* ☐ No ☐ Yes
- *Prostate problems* ☐ No ☐ Yes
- *Menstrual problems* ☐ No ☐ Yes

Musculoskeletal
- *Bone problems (Osteoporosis)* ☐ No ☐ Yes
- *Joint problems (Rheumatoid)* ☐ No ☐ Yes
- *Inflammatory Arthritis* ☐ No ☐ Yes

Integuementary
- *Skin problems* ☐ No ☐ Yes

Neurologic
- *Balance problems* ☐ No ☐ Yes
- *Numbness; tingling* ☐ No ☐ Yes
- *Migraine Headaches* ☐ No ☐ Yes
- *Epilepsy; seizures* ☐ No ☐ Yes

Psychiatric
- *Depression* ☐ No ☐ Yes
- *Anxiety* ☐ No ☐ Yes
- *Other Psychological Problems:* ☐ No ☐ Yes
  - *Explain*: ________________

Endocrine
- *Thyroid gland problems* ☐ No ☐ Yes
- *Diabetes* ☐ No ☐ Yes

Hematologic/Lymphatic
- *Bleeding problems* ☐ No ☐ Yes
  - *Explain:* ________________
- *Anemia* ☐ No ☐ Yes

Cancer ☐ No ☐ Yes
- *Type*: ________________

Other Illnesses
- *AIDS* ☐ No ☐ Yes
- *Sexually Transmitted Diseases* ☐ No ☐ Yes
- *Tuberculosis* ☐ No ☐ Yes
- *Other* ☐ No ☐ Yes
  - *Please Specify*: ________________

Describe any "yes" responses from above:

____

Patient Signature/Legal Representative____________________ Date:__________

(If Under 18 Parent/Guardian Must Sign)

Reviewed By____________________ Date:__________