Today's Date:

Texas Orthopedic Partners

4401 Coit Road, Suite 203 Frisco, Texas 75035 Phone: (469) 800-7070 Fax: (469) 800-7080

New Orthopedic Surgery Patient Medical History Form

Patient Name DOB:

Name of Primary Care Physician:	Are you right or left handed?
What is your occupation?	
What Pharmacy do you use:	
List your Medications here: (Please include strength and dosage)	
Please list all Allergies Here:	

Problem History Background

What is your main complaint?	What is the date of your injury? How long has this complaint been present? Months Years
Please indicate your current pain level 0 1 2 3 4 5 6 7 8 9 10	What makes your pain **better**? Rest Heat Cold Medication Exercise Other_____
What words best describe how the pain feels? Sharp Burning Shooting Deep Stabbing Throbbing Aching Pressure Dull Tingling Other_____	What makes your pain **worse**? Rest Heat Cold Medication Exercise Other_____

Treatment History:

Have you ever been treated by another physician? YES NO

If Yes who:_____

Have you had surgery intended to treat your current complaint? YES NO

If Yes, What type of surgery?_____

Have you had X-Rays, MRI, CT scan or other Radiologic Imaging for this problem? YES NO

If Yes, What type of testing?_____

Have you had an Electromyography or EMG/NCV test to evaluate nerve function? YES NO

If Yes, who performed?_____

Have you tried Activity Modification? YES NO

If Yes, What did you modifiy?_____

Have you tried NSAIDS? YES NO

If Yes, What have you tried?_____

Have you gone to Physical Therapy for this complaint? YES NO

If Yes, Which facility did you go to?_____

Have you had any injections for this complaint? YES NO

If Yes, what type of injections did you have?_____

Medical History-

AIDS/HIV	Congestive heart failure	GERD	Multiple sclerosis	Scoliosis
Alcoholism	COPD	Gout	Myocardial infarction	Seizure disorder
Alzheimer's	Coronary artery disease	Hepatitis	Obesity	Sleep apnea
Anemia	Crohn's disease	Hyperlipidemia	Osteoarthritis	SLE
Angina	Degenerative joint disease	Hypertension	Osteoporosis	Spinal stenosis
Arthritis	Depression	Inflammatory bowel disease	Parkinson disease	Spondyloarthopathy
Asthma	Diabetes	Juvenile rheumatoid arthritis	Peptic ulcer disease	Thyroid disease
Atrial fibrillation	Drug abuse	Kidney disease	Psoriasis	Valvular disease
Enlarged Prostate	DVT	Liver disease	PVD	OTHER:
Cancer	Fibromyalgia	Lyme disease	Renal disease	
Cerebrovascular incident	Gallbladder disease	Migraine headaches	Rheumatoid arthritis	

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Surgical History-

ACL surgery:	Arthroscopy wrist:	Colostomy:	LASIK:	OTHER:
Angioplasty:	Arthroscopy shoulder:	Discectomy:	Meniscus surgery:	
Angio w/stent:	Back surgery:	Gastric bypass:	Muscle biopsy:	
Appendectomy:	CABG:	Hernia repair:	ORIF:	
Arthroscopy ankle:	Cardiac valve replacement:	Hip arthroplasty:	Pacemaker:	
Arthroscopy elbow:	Carpal tunnel release:	Hip replacement:	Small bowel resection:	
Arthroscopy hip:	Cataract extraction:	Knee replacement:	Thyroidectomy:	
Arthroscopy knee:	Cholecystectomy:	Laminectomy:	Tonsillectomy:	

Family History– Please list medical problems of your immediate family such as diabetes, high blood pressure, heart disease, etc.

Relation	Medical Condition	Relation	Medical Condition

Constitutional

Chills

Weight Loss

Malaise/Fatigue

Diaphoresis (Excessive Sweating)

Weakness

Skin

Rash

Itching

HENT

Headaches

Hearing Loss

Tinnitus

Ear Pain

Ear Discharge

Nosebleeds

Congestion

Stridor– (Vibrating Noise when breathing)

Sore Throat

Eyes

Blurred Vision

Double Vision

Photophobia (Sensitivity to light)

Eye Pain

Eye Discharge

Eye Redness

Cardiovascular

Chest Pain

Palpitations

Orthopnea

Claudication (cramping pain caused by obstruction in arteries)

Leg Swelling

PND– attacks of shortness of breath and coughing at night)

Respiratory

Hemoptysis-(Coughing up blood)

Sputum Production– (Excessive mucus)

Shortness of Breath

Wheezing

Gastrointestinal

Heartburn

Nausea

Vomiting

Abdominal Pain

Diarrhea

Constipation

Blood in Stool

Melena– (Dark, Sticky stool)

Genitourinary

Dysuria– (Painful urination)

Urgency

Frequency

Hematuria– (Blood in urine)

Flank Pain

Musculoskeletal

Myalgias- (Muscle pain)

Neck Pain

Back Pain

Joint Pain

Falls

Endo/Hem/Aller

Easy Bruise/bleed

Environmental Allergies

Polydipsia-(Great feeling of thirst)

Neurological

Dizziness

Tingling

Tremor

Sensory Change

Speech Change

Focal Weakness

Seizures

LOC– (Loss of Consciousness)

Psychiatric

Depression

Suicidal Ideas

Substance Abuse

Hallucinations

Nervous/Anxious

Insomnia

Memory Loss

I attest that everything stated here is true to the best of my knowledge:

Patient Signature: _____ **Date:** _____

I have personally reviewed this form with the patient:

Provider Signature: _____ **Date:** _____