

NORTHSIDE CHEROKEE ORTHOPEDICS & SPORTS MEDICINE

Name: _____ DOB: _____ Height: _____ Weight: _____

Referred by: _____ Primary Care Physician: _____

Have you seen another physician regarding this condition? Yes / No If yes, list names and dates: _____

How did you hear about us? Friend / Family, Internet, Insurance, Urgent Care, Other: _____

PAST MEDICAL HISTORY

• Neurological

Stroke	YES	NO
Concussion	YES	NO
Peripheral Neuropathy	YES	NO
Epilepsy/Seizures	YES	NO

• Cardiovascular

Heart Attack	YES	NO
High Blood Pressure	YES	NO
Coronary Artery Disease	YES	NO
Elevated Cholesterol	YES	NO
A-Fib/Irregular Heartbeat	YES	NO
Pacemaker	YES	NO

• Kidney

Renal Insufficiency	YES	NO
Kidney Stones	YES	NO
One Kidney/Abnormal Kidney	YES	NO

• Gastrointestinal

Ulcers	YES	NO
Reflux	YES	NO
Intolerance to NSAIDS	YES	NO

• Skin

Psoriasis	YES	NO
History of Skin Rash	YES	NO

• Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO
Prednisone Use	YES	NO

• Pulmonary

Sleep Apnea/CPAP	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
COPD	YES	NO
Pulmonary Embolism	YES	NO

• Infectious

HIV/AIDS	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
TB	YES	NO
Recent Tick Bite	YES	NO
MRSA	YES	NO

• Cancer

Type:	YES	NO

• Musculoskeletal

Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Fibromyalgia	YES	NO
Osteoporosis	YES	NO
Gout	YES	NO

• Hematological

Bleeding Problems	YES	NO
Blood Clots	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO

If you answered yes to any questions, please explain:

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Problem Not Listed

Explain:	YES	NO

ALLERGIES:

I have no allergies to medicine I have no allergies to foods Allergic to metal Yes No

Allergic to:	Reactions:

CURRENT MEDICATIONS: (Include dosage) If dosage is missing, patient advised to bring in an updated medication list

HISTORY AND PHYSICAL

PAST SURGICAL PROCEDURES: (Please list all and year)

REVIEW OF SYSTEMS Are you currently experiencing any of the following?

• **Constitutional**

Recent weight loss	YES	NO
Fever/Chills	YES	NO

• **Musculoskeletal**

Joint pain	YES	NO
Joint swelling	YES	NO

• **Cardiovascular**

Chest pain	YES	NO
Heartburn	YES	NO

• **Genitourinary**

Painful or frequent urination	YES	NO
Bowel or bladder changes	YES	NO

• **Psychiatric**

Depression	YES	NO
Anxiety	YES	NO
Claustrophobic	YES	NO

• **Integument (Skin)**

Rashes	YES	NO

• **Heme-Lymph**

Easy bleeding	YES	NO

• **Neurological**

Dizziness	YES	NO
Fainting	YES	NO

• **Respiratory**

Shortness of breath	YES	NO

• **Allergic/Immunologic**

Metal sensitivity or allergy	YES	NO

• **Other**

Immunizations:

Have you had a pneumonia vaccine in the past year? Yes No If yes, month/year _____.

FAMILY HISTORY: (parents, siblings and grandparents)

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Unknown Family Medical History | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Hip/Spine Fracture | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | | |

SOCIAL HISTORY:

Are you currently pregnant or nursing? Yes No
 Do you currently use tobacco products? Yes _____ ppd No
 Quit smoking? Yes No
 How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____
 Do you currently use or have a history of illicit substance abuse? Yes No _____

EMOTIONAL/SPIRITUAL/CULTURAL NEEDS:

Mental/Emotional: Anxiety Depression Job Loss Divorce Death of Someone Close to You New Job
 Under Care of Psychiatrist/Psychologist Name: _____ Live alone? Yes No
 Do you have concerns about your safety, the safety of anyone in your home or security of your property? Yes No

Patient's signature: _____ Date/Time: _____