Medical History Form

Vipul Dua MD Christin Del Buono PA-C

Patient Name:_____ Date:_____
Age:_____ Sex: ☐F☐M Dominant Hand ☐Right ☐Left **Height**_____ **Weight**_____
Who referred you to our office?_____ Who is your **Primary Care** Physician?_____
Are you **ALLERGIC** to or **have reactions** to any **medications, latex, metal or food**? ☐ No ☐ Yes If YES, Describe:__
_____
List **ALL** medications, herbs, supplements you take **now**: _____
_____

Are you on any **BLOOD THINNERS, NSAIDs or ASPIRIN**? If Yes, which ones_____
Which body part are we seeing you for? ☐ **Right** ☐**Left**
☐**Shoulder** ☐ **Elbow** ☐**Wrist** ☐**Hand** ☐**Hip** ☐**Knee** ☐**Ankle** ☐**Foot** ☐**Neck** ☐**Back** ☐**Other**_____
What is the reason for you visit? ☐Pain ☐Numbness ☐Weakness ☐Swelling ☐Stiffness
How long has this pain been bothering you? _____days/ weeks/ months /years
Have you had a problem like this before? ☐No ☐Yes If yes, how long ago?_____
Check the **ONE** box that best described how your problem started:
☐**No Injury** Onset was ☐gradual ☐sudden
☐**Injury** ☐ accident ☐sport Date:_____ Describe_____
☐**Injury at work** Date:_____ ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach☐other_____
☐**Work related** (but NO injury)Date:_____ How did your job cause the problem?_____
☐**Auto Accident** Date:_____ How was your car hit?_____
Describe Symptoms

On a 1-10 scale (10 is worst) how **severe** is your pain? (circle) 1 2 3 4 5 6 7 8 9 10
What is the QUALITY of the pain? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning
The pain is: ☐constant ☐comes and goes(intermittent) Does the pain wake you from sleeping?☐Yes☐No
Since it **started**, the pain is: ☐getting better ☐getting worse ☐unchanged
Do you **now** have: ☐swelling ☐ bruising ☐numbness ☐tingling ☐weakness ☐loss of bowel or bladder control
☐ locking ☐catching ☐giving away ☐stiffness/pain when standing
What makes the pain **worse**?☐ standing ☐walking ☐lifting ☐exercise ☐twisting ☐lying down☐bending ☐stairs
☐ squatting ☐kneeling ☐sitting ☐coughing ☐sneezing ☐reaching over head
Which of these makes symptoms **better**?☐rest ☐ice ☐heat ☐elevation☐other_____
Have you had any of these treatments? ☐ injection ☐brace ☐ therapy ☐cane/crutches ☐medication ☐none
Were you seen in the ER for this problem? ☐ yes ☐no Which ER?_____ Date:_____
What tests have you had for this problem?☐ X-rays ☐MRI ☐CT ☐Bone Scan ☐nerve test(EMG) ☐lab work
Where were they done?_____ Did you bring them today? ☐Yes ☐No

Have you ever had surgery for a problem in the same area?☐ No☐Yes Please list below if yes.
Procedure:_____ Date:_____ Surgeon:_____ City:_____
Procedure:_____ Date:_____ Surgeon:_____ City:_____

Current work status: ☐regular duty ☐light duty- (how long)_____☐Disabled ☐Retired ☐Student
When was the last date you worked your regular job?_____
Are you currently receiving or applying for: ☐ Disability ☐Worker's Comp ☐Unemployment ☐None
Have you had a prior problem with the same orthopedic condition in the past? ☐ Yes ☐No
If yes, describe:_____

Patient Name:_____Date:_____

REVIEW OF SYSTEMS

Do your other joints have: ☐ morning stiffness over 30 minutes ☐joint pain or swelling ☐back pain ☐Gout ☐Rheumatoid arthritis ☐ osteoporosis ☐prior fracture(which bone)_____ ☐ none of these

Do you have any of these symptoms? If none, please check the box labeled "NONE" .

GI	☐heart burn/ ulcers/ reflux ☐ IBS/ Chron's ☐ blood in stool ☐hepatitis ☐liver disease	☐none
ENDO	☐thyroid disease ☐ heat or cold intolerance	☐none
CON	☐weight loss ☐loss of appetite	☐none
EYE	☐blurred vision ☐double vision ☐vision loss	☐none
ENT	☐hearing loss ☐hoarseness ☐trouble swallowing	☐none
CV	☐chest pain ☐palpitations ☐cardiac stents ☐pacemaker	☐none
RS	☐chronic cough ☐shortness of breath ☐asthma	☐none
GU	☐painful urination ☐blood in urine ☐kidney problems	☐none
SK	☐frequent rashes ☐skin ulcers ☐lumps ☐psoriasis	☐none
NEU	☐headaches ☐dizziness ☐seizures ☐MS	☐none
PSY	☐depression/anxiety ☐drug/alcohol addiction ☐sleep disorder	☐none
HEM	☐easy bleeding ☐easy bruising ☐anemia ☐blood clots	☐none

ARE YOU HIV POSITIVE? ☐yes ☐no

PAST MEDICAL HISTORY

Are you diabetic?☐ yes ☐no If yes, treatment: ☐insulin ☐oral meds. ☐ diet ☐none

Please list any **surgeries/ hospitalizations** for illness or injury, you have had and when they were done. ☐none list if yes _____

_____

_____

Have you or a family member had a reaction to anesthesia? ☐ no ☐yes explain_____

Have you been on blood thinners in the past? ☐ No ☐ Yes If yes, which one(s)_____

Have you ever had any of the following:☐heart attack (year_____) ☐high blood pressure(year____)

☐blood clots(year____) ☐stroke ☐heart failure ☐ankle swelling ☐kidney failure ☐cancer(location_____)

☐stomach ache while taking anti-inflammatories (ex. Advil/Aleve/ Motrin) If yes, which one_____

☐I do not have any of these conditions

Family History- Have any of your direct relatives had any of the following disorders? If so which relative?

☐ diabetes ☐high blood pressure ☐rheumatoid arthritis ☐none If yes, who_____

_____

Social History- Do you smoke? ☐no ☐yes If so, how much per day?_____

Use other tobacco products? ☐yes ☐no Has patient been informed of smoking risks? ☐yes ☐no

Do you drink alcohol? ☐yes ☐no If yes, how much, how often?_____

Marital status: ☐married ☐single ☐widowed ☐divorced How many people live with you?_____

Occupation:_____ Employer:_____☐student

Please sign: The information on this form is accurate to the best of my knowledge.

Patient/ Guardian Signature:_____**Date:**_____

MD NOTES:

Provider Signature_____**Vipul Dua MD Christin Del Buono PA-C Date:**_____