COASTAL ORTHOPEDICS

# LOWER EXTREMITY ESTABLISHED PATIENT MEDICAL HISTORY UPDATE

**Date of visit:** ____ /____ /____ **Who are you seeing today:**_____

## YOUR INFORMATION

**Full name:** _____

**Date of birth:** ____ /____ /_____

**Height:** _____ **Weight:** _____

**Hand dominance:** ☐ Right ☐ Left ☐ Ambidextrous

**Primary care physician:**

## PLEASE INDICATE ANY NEW MEDICATIONS SINCE LAST VISIT

**Are you currently, or will you be initiating, the use of Medical Marijuana for any reason?** ☐ Yes ☐ No

**Are you taking Aspirin or any other blood thinners?** ☐ Yes ☐ No

☐ Yes ☐ No **I consent to securely pull my medications from the pharmacy database, and reconcile with the Medical Assistant**

**List all the medications you take, both prescription & nonprescription below:**

☐ **No medications to list** ☐ **See attached list of medications**

| Medication or Brand Name | Dose | Medication or Brand Name | Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## YOUR ALLERGIES

☐ **No new allergies** **Indicate all the allergies you have to medications and/or food & describe reaction below:**

Common reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

## PLEASE INDICATE ANY NEW MEDICAL HISTORY SINCE LAST VISIT

☐ **No new relevant medical history**

| | | | |
|---|---|---|---|
| ☐ Hypertension | ☐ Kidney disease | ☐ Obesity | ☐ AIDS/HIV |
| ☐ Heart disease: _____ | ☐ Diabetes – I or II | ☐ Peripheral vascular disease | ☐ Ulcers |
| ☐ Osteoarthritis | ☐ Osteoporosis | ☐ Anxiety | ☐ DVT/blood clots |
| ☐ Rheumatoid arthritis | ☐ Cancer– Type: _____ | ☐ Depression | ☐ Stroke |

**Any additional medical history information:**

## SURGICAL HISTORY SINCE LAST VISIT

☐ **No new surgical history**

| | | | |
|---|---|---|---|
| ☐ Hip replacement – RT/LT | Date: ____/____/_____ | ☐ Fracture – Type: _____ | Date: ____/____/_____ |
| ☐ Knee replacement – RT/LT | Date: ____/____/_____ | ☐ Pacemaker | Date: ____/____/_____ |
| ☐ Shoulder/rotator cuff – RT/LT | Date: ____/____/_____ | ☐ Open heart/by-pass | Date: ____/____/_____ |
| ☐ Carpal tunnel – RT/LT | Date: ____/____/_____ | ☐ Spine – type/level: _____ | Date: ____/____/_____ |
| ☐ Arthroscopy – Type: _____ | Date: ____/____/_____ | ☐ Other: _____ | Date: ____/____/_____ |

**Any additional surgical information:**

## DIAGNOSTIC HISTORY SINCE LAST VISIT

| Study | Date | Results |
|---|---|---|
| **X-RAYS** | _____ /_____ /_____ | |
| **MRI/CT** | _____ /_____ /_____ | |
| **EMG/nerve conduction studies** | _____ /_____ /_____ | |
| **Myelogram** | _____ /_____ /_____ | |
| **Bone scan / DEXA scan** | _____ /_____ /_____ | |

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# LOWER EXTREMITY ESTABLISHED PATIENT MEDICAL HISTORY UPDATE

## YOUR SOCIAL HISTORY

**Tobacco Use:** ☐ Current ☐ Former ☐ Never **If Current**, have you ever tried to quit? ☐ Yes ☐ No

Type: _____ Packs/Day: _____ Years used: _____

**Alcohol Use:** ☐ Yes ☐ No ☐ Former **If Yes**, select type: ☐ Beer ☐ Wine ☐ Liquor

Frequency: _____ Amount per sitting: _____ Last drink: _____

**Which of the following drugs or substances. if any, have you used in the PAST? (Please check all that apply)**

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____

**Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)**

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____

## REVIEW OF SYSTEMS

☐ **All Negative Below** **Check if you have any of the following:**

| General | Cardiovascular | Metabolic | Skin |
|---|---|---|---|
| ☐ Fever | ☐ Heart murmur | ☐ Cold intolerance | ☐ Rash |
| ☐ Weakness | ☐ Leg swelling/edema | ☐ Heat intolerance | ☐ Skin infections |
| ☐ Weight gain/loss (circle one) | ☐ Syncope/fainting | | ☐ Skin lesions |
| **Ears, Nose & Vision** | **Gastrointestinal (GI)** | **Neurological** | **Blood Disorders** |
| ☐ Blurred vision | ☐ Constipation | ☐ Difficulty walking | ☐ Bleeding |
| ☐ Facial pain | ☐ Diarrhea | ☐ Dizziness | ☐ Bruising |
| ☐ Headache | ☐ Nausea | ☐ Poor coordination | |
| ☐ Vertigo/dizziness | ☐ Vomiting | ☐ Muscle weakness | |
| **Respiratory** | **Urinary** | **Psychiatric** | **Immune System** |
| ☐ Dyspnea (difficulty breathing) | ☐ Dysuria (difficulty urinating) | ☐ Anxiety | ☐ Asthma |
| ☐ Recent infections | ☐ Frequent urination | ☐ Depression | ☐ Environmental allergies |
| ☐ Wheezing | ☐ Hematuria (blood in urine) | ☐ Insomnia | ☐ Food allergies |

## YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan.

**Patient signature:** **Date:** ____ /____ /____

**If minor, guardian signature:** **Date:** ____ /____ /____

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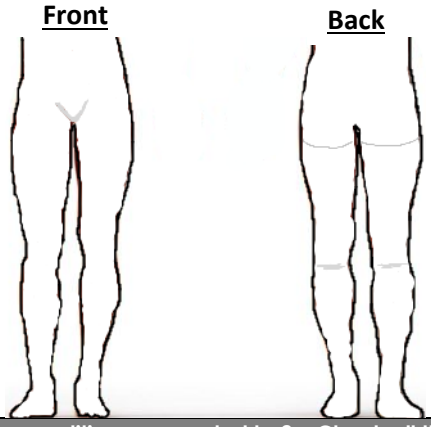
# LOWER EXTREMITY CONDITION

**Patient name: _____ Date of birth ___/___/_____ Today's date___/___/_____**

| Tell us about the reason for your visits today |
|---|
| **What is the reason for your visit today?** |
| **When did this condition start (onset)?** |
| **Place of injury?** ☐ Sports ☐ Home ☐ Auto Accident ☐ Workplace ☐ School ☐ Non-applicable |
| **How often does the condition occur?** ☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent |
| **What is the status of your condition since the onset date?** ☐ Unchanged ☐ Improving ☐ Fluctuating ☐ Stable ☐ Worse ☐ Resolved |
| **What is the severity of your pain/numbness at its worst? (Circle a number) No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating** |
| **What type of pain are you experiencing? Check all that apply.** |
| ☐ None ☐ Ache ☐ Burning ☐ Discomfort ☐ Dull ☐ Numbness ☐ Piercing ☐ Sharp |
| ☐ Shooting ☐ Stabbing ☐ Electric ☐ Deep ☐ Throbbing ☐ Tearing ☐ Localized ☐ Diffuse |
| **Location of Pain:** *On the diagram below **"SHADE"** all areas where you feel pain and **"X" the areas that hurt the most*** |




| Is your condition aggravated by? Check all that apply | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Nothing | ☐ Daily activity | ☐ Ascending stairs | ☐Descending stairs | ☐ Jumping | ☐ Kneeling | ☐ Squatting |
| ☐ Movement | ☐ Physical therapy | ☐ Lifting weight | ☐ Pushing | ☐ Bending | ☐ Rotation/ twisting | ☐ Exercise |
| ☐ Lying down | ☐ Standing | ☐ Sitting | ☐ Sleeping | ☐ Weather changes | ☐ Walking | ☐Other: _____ |

| Is your condition relieved by? Check all that apply | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Nothing | ☐ Ice | ☐ Heat | ☐ Elevation | ☐ Mobility | ☐ Rest | ☐ Stretching |
| ☐ Exercise | ☐ Brace | ☐ Massage | ☐ Physical therapy | ☐ Injection | ☐ Over the counter meds | ☐ Pain medication |

**Tell us about your past medical history**

| ☐Never been treated for condition | Start Date | ☑ Receiving now | End Date | Name of facility where treatment was completed | % of relief 0-100 |
|---|---|---|---|---|---|
| **Activity modification** | ___/___/____ | ☐ | ___/___/____ | | |
| **Bracing** | ___/___/____ | ☐ | ___/___/____ | | |
| **Injection/nerve block** | ___/___/____ | ☐ | ___/___/____ | | |
| **Drug/medication therapy** | ___/___/____ | ☐ | ___/___/____ | | |
| **Physical therapy** | ___/___/____ | ☐ | ___/___/____ | | |
| **Physician prescribed home exercise** | ___/___/____ | ☐ | ___/___/____ | | |
| **Resting the area** | ___/___/____ | ☐ | ___/___/____ | | |
| **TENS unit** | ___/___/____ | ☐ | ___/___/____ | | |
| **Other: _____** | ___/___/____ | ☐ | ___/___/____ | | |