

Orthopaedic Specialists of Central Arizona

Judah D Pifer, MD • Brad D Williams, MD

Patient Medical History – Lower Extremity

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Occupation: _____ Retired? Yes No

Primary Care Doctor: _____ Who referred you to our office? _____

What are you being seen for today? _____

Have you seen a doctor for this problem before? No Yes If yes, who? _____

When did your current problem begin to cause you symptoms? _____

Did a specific injury or accident start your symptoms? No Yes Is Injury Work-Related? No Yes

If Yes, when was the injury/accident and how did it occur? _____

Are you currently involved in an accident or disability litigation/legal action? No Yes

Were images taken? (Xray or MRI) No Yes If yes, where? _____

On a scale of 0 – 10, (0 meaning no pain and 10 meaning the worst pain imaginable) how severe is your pain?

Most of the time: 0 1 2 3 4 5 6 7 8 9 10

When the pain is the worst: 0 1 2 3 4 5 6 7 8 9 10

When the pain is the least: 0 1 2 3 4 5 6 7 8 9 10

Has your pain recently: Worsened Not changed Improved Gone away

Describe the type of symptoms you experience (check all that apply):

Sharp/stabbing Throbbing Shooting Aching Cramping Stiffness

Burning Tingling Numbness

Describe when your pain occurs (check all that apply):

Worse in the morning Worse during the middle of the day Worse at the end of the day

Keeps or wakes me up at night Does not vary significantly during the day

Have you taken any medicines for your pain?

Tylenol NSAID's Narcotic pain pills Glucosamine/Chondroitin/MSM-type supplements

Have you had any prescribed treatment for your pain?

- Physical Therapy Cortisone injections Lubricating injections (Synvisc, Supartz, Euflexxa)
 Other: _____

Pain is made worse by (check all that apply):

- Walking Running Standing Climbing Going up stairs Going down stairs
 Bending Squatting Kneeling Sitting Driving Lying down Exercise

Pain is made better by (check all that apply):

- Walking Sitting Standing Bending Resting Lying down
 Heat Ice Exercise Nothing in particular makes the pain better

Please describe any limitations in your activity caused by your pain or other symptoms:

- Walk no more than _____ yards/miles; Sit no longer than _____ min/hours at a time
 Stand no longer than _____ min/hours at a time; Climbing stairs;

Do you use a cane, crutches, or a walker? No Yes If yes, please circle which one.

Please list all operations you have had (name and date):

How often do you exercise? Daily 1-2d/wk 3-4d/wk >5 d/wk

What types of exercise do you usually do? _____

Do you smoke or chew tobacco? (please circle) No Yes If yes, how much and for how long? _____

Have you used tobacco in the past? No Yes If yes, when did you quit? _____

How many alcoholic beverages do you have in a day? _____ A week? _____

Have you ever used or currently use illegal IV drugs? No Yes If yes, please explain: _____

Have you had or now have any infectious diseases such as MRSA infection, Hepatitis, Tuberculosis, HIV/AIDS?

No Yes If so, please list: _____

Height: _____ Weight: _____

Patient name: _____ Date of Birth: _____

Review of Systems

In the past week have you experienced any of the following problems? Please circle all that apply:

- | | | | |
|--------------------|---------------------|-------------------------|-------------------|
| Fever | Sore throat | Nausea/vomiting | Depression |
| Chills | Bloody sputum | Constipation/diarrhea | Poor sleep |
| Weight loss | Cough | Urination problems | Anxiety |
| Weight gain | Swollen glands | Kidney/bladder problems | Tremors |
| Night sweats | Chest pain | Sore joints | Seizures |
| Fatigue | Swollen feet | Muscle aches | Infections |
| Vision problems | Shortness of breath | Skin rash | Fainting |
| Hearing difficulty | Abdominal pain | New moles | Headaches |
| Nasal congestion | Ulcers | Dizziness | Bleeding problems |
- Other : _____ I have had none of the above problems

What diseases, if any, are common in your family? (i.e. diabetes, heart attacks, cancer, etc.)

Please indicate any and all medical conditions for which you have been treated:

<u>Under current active or past treatment?</u>	<u>Current</u>	<u>Past</u>	<u>Under current active or past treatment?</u>	<u>Current</u>	<u>Past</u>
Heart disease or heart attack (circle)			Gastritis/Reflux disease (circle)		
Pacemaker			Leukemia/Lymphoma (circle)		
Congestive heart failure			Thyroid disease		
Irregular heart beat			Liver disease or Cirrhosis (circle)		
Hypertension (High blood pressure)			Kidney disease		
Diabetes			Bladder infection		
Blood clots in your legs or lungs (circle)			Prostate difficulty		
Stroke			Severe body aches/ Fibromyalgia (circle)		
Osteoporosis (weak bones)			Medical Implants:		
Bleeding problems / Anemia (circle)			MRSA infection		
COPD/Emphysema/Bronchitis (circle)			Tuberculosis		
Sleep Apnea			HIV/AIDS		
Stomach/Intestinal Ulcer (circle)			Rheumatoid Arthritis		
Other:			Other:		

*Current Mailing Address: _____

*Current Phone Number: _____

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

*We, at OSCA, assure you that the above information is part of your personal and private medical record. As such, it will not be shared with anyone outside this office without your specific, written permission, except for circumstances wherein we are required to do so by law.

