BLUEGRASS ORTHOPAEDICS

PATIENT HISTORY

Please PRINT and fill out completely

Today's Date: ____________ Patient# ________________________ DOB: ______________ Account# ____________________

Name: ____

Age: _____ Height: ______ Weight: _______ Hand Dominance: ☐ Left ☐ Right

Referring Physician: __________________________________ Primary Care Physician: ____________________________________

PHARMACY NAME AND ADDRESS: ____

MEDICATIONS

Please list medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin and any over the counter medications. Include Vitamin, Mineral and herb supplements.

Medication	*Dosage*	*Frequency*

*****I understand that it's my responsibility to advise of any updates to any/all medications reported should there be a change. *****

ALLERGIES

Latex: ☐ Yes ☐ No Metal Allergies (Earrings): ________________________ ☐ Nickel Allergy

Are you allergic to any medication: ☐ Yes ☐ No

Please list all medications that you are allergic to: ____

____

HISTORY OF INJURY:

Did the problem result from a specific injury? ☐ Yes ☐ No Injury/Accident Date: ________________________

Did your problems begin following: ☐ Work Injury ☐ Motor Vehicle Accident What State? ____________________________

How did you get injured? ____

If neither, how long have you had the condition? ____

Please rate your pain on a scale of 1 to 10 (10 being the most painful): ____

Is the Pain: ☐Constant ☐ Occasional ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing

What symptoms are you experiencing? ☐ Locking ☐ Catching ☐ Giving Way ☐ Popping ☐ Grinding ☐ Other

What, if anything, makes your symptoms *better*? ____

What, if anything, makes your symptoms *worse*? ____

Have you seen another physician for this injury? ☐ Yes ☐ No

If yes, who? ____

What treatments have you tried for this injury? ☐ Nothing ☐ Physical Therapy ☐ Exercise ☐ Acupuncture

☐ Chiropractic ☐ injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)

☐ Medications: ____ ☐ Other: ____

Patient Name:____ Practitioner's Initials:____________

Have you ever had the following tests for this injury?

Test	Date *(month/year)*	What facility? *(clinic/hospital)*
☐ X-Rays	____________	____________
☐ MRI scan	____________	____________
☐ CT scan	____________	____________
☐ EMG/NCV	____________	____________
☐ Discogram	____________	____________
☐ EKG	____________	____________
☐ Blood tests	____________	____________
☐ Other	____________	____________

PAST SURGICAL HISTORY

Please check any previous surgical procedures, list the date and describe the surgery:

☐ Appendectomy ☐ Gallbladder ☐ Hernia Repair ☐ Arthroscopy
☐ Heart Surgery ☐ Spine Surgery ☐ Total Joint replacement ☐ Previous Fracture
☐ Hysterectomy ☐ Other:____

SOCIAL HISTORY

Special Diet:	☐ Yes	☐ No	Any Restrictions?____________________
Tobacco Use:	☐ Yes	☐ No	Type: __________ Duration: __________ Quit Date:__________
Alcohol Use:	☐ Yes	☐ No	Frequency?____________________
Drug Use:	☐ Yes	☐ No	Frequency?____________________
Caffeine Use:	☐ Yes	☐ No	Frequency?____________________
Exercise:	☐ Yes	☐ No	Frequency?____________________

IMMUNIZATION

☐ Pneumococcal Pneumonia / Date: ☐ Influenza Vaccine / Date:

MEDICAL HISTORY

Please check current or previous medical conditions:

☐ Anemia ☐ Depression ☐ Hepatitis A B or C ☐ Heart Attack/Stroke
☐ Arthritis ☐ Diabetes ☐ High Blood Pressure ☐ Rheumatoid
☐ Asthma ☐ Emphysema ☐ HIV ☐ Thyroid
☐ Blood Clots ☐ Heart Disease ☐ Irregular Heartbeat ☐ Diverticulitis
☐ Cancer ☐ Liver Disease ☐ Osteoporosis ☐ Heartburn/Acid Reflux
☐ Blood Transfusion ☐ History of Fractures ☐ Sleep Apnea / Breathing Issues ☐ Use of CPAP
☐ Other:____

FAMILY HISTORY

Please check family history conditions:

☐ Blood Clots ☐ Diabetes ☐ Osteoporosis ☐ Cancer
☐ Heart Disease ☐ Hypertension ☐ Rheumatoid Arthritis ☐ Stroke/Seizures

Please describe any immediate family history of medical problems:____________________

____

____

Patient Name:____ Practitioner's Initials:____________

REVIEW OF SYMPTOMS

Check if you have current symptoms or current known medical problems in the following areas. Please describe.
If you do not have any problems, please check in the negative box.

1. CONSTITUTIONAL GENERAL
☐ None ☐ Weight Loss ☐ Weight Gain ☐ Insomnia ☐ Chronic Fatigue
☐ Other:____________________

2. EYES
☐ None ☐ Vision Change ☐ Glasses/Contacts ☐ Cataracts ☐ Glaucoma
☐ Other:____________________

3. EARS, NOSE, THROAT
☐ None ☐ Loss of Hearing ☐ Seasonal Allergies ☐ Sinus Pain ☐ Ringing
☐ Other:____________________

4. CARDIOVASCULAR
☐ None ☐ Chest pain ☐ Edema ☐ Hypertension ☐ Palpitations
☐ High Cholesterol Other:____________________

5. RESPIRATORY
☐ None ☐ Asthma ☐ Wheezing ☐ Frequent Cough
☐ Other:____________________

6. GASTROINTESTINAL
☐ None ☐ Heartburn ☐ Indigestion ☐ Acid Reflux ☐ Ulcer Problems
☐ Abdominal Pain ☐ Peptic Ulcer ☐ GI Stomach Bleed
☐Other:____________________

7. MUSCULOSKELETAL
☐ None ☐ Arthritis ☐ Muscle Weakness ☐ Joint Pain ☐ Back Pain
☐ Other:____________________

8. SKIN
☐ None ☐ Rash ☐ Ulcers ☐ Scars
☐ Other:____________________

9. NEUROLOGICAL
☐ None ☐ Headaches ☐ Seizures ☐ Numbness ☐ Dizziness
☐ Other:____________________

10. PSYCHIATRIC
☐ None ☐ Depression ☐ Crying ☐ Anxiety ☐ Mood Swing
☐ Other:____________________

11. ENDOCRINE
☐ None ☐ Diabetes ☐ Hypothyroid ☐ Hyperthyroid ☐ Hot Flashes
☐ Other:____________________

12. HEMATOLOGY
☐ None ☐ Easy Bruising ☐ Bleeding ☐ Anemia
☐ Other:____________________

By filling out the below information, I acknowledge that all above information is correct and current:

Print Name: ______________________________ Date: ____________________

Date of Birth: ______________________________