Orthopaedic Surgery & Sports Medicine
OF SAN ANTONIO

Revised 07/01/09

CURRENT VISIT/ MEDICAL HISTORY

This questionnaire collects information about your current state of health to assist the medical team with your care and help us meet requirements established by Medicare and other insurers. This information will be stored electronically and reformatted for your medical record. Thank You for filling this information out accurately as it helps us provide you with the best possible care.

Answer ALL questions by filling in the appropriate circle(s) and by PRINTING the requested information in the appropriate box. All unanswered questions will be returned for you to complete prior to your visit with the clinician. Please complete answers by filling in the circles like ●

Today's Date:______________________

Patient Name:______________________________

1. If any of the above information is incorrect, please inform the receptionist
2. Who completed this form? O Self O Parent O Spouse/Family Member O Guardian O Other

A. Healthcare Provider Information & Authorization to Release Information

3. Do you have a regular physician?
   O No O Yes - print name, title, phone and address below:

   Name/Title:________________________________ Phone: __________________________

   Address: ____

   City/State/Zip: ____

4. Do you wish us to forward information from your visit today to your primary physician? ☐ Yes ☐ No

B. Medications

5. Please list any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal therapy and cold medications you are currently taking.

   O I am not taking any medications

Name of Medication	Dose Strength	How often taken (e.g. 12x per day)	Name of Medication	Dose Strength	How often Taken (e.g. 12x per day)

6. If you are taking more medications than space provided please bring a list to your appointment.

Continue on next page …

Staff Initials ___________

CURRENT VISIT/ MEDICAL HISTORY

7. Are there any other medications you have used in the past month and are no longer taking? ○ No ○ Yes
(If yes, please bring a list to your appointment)

8. Have you taken aspirin containing products in the last two weeks? ○ No ○ Yes
9. Have you taken steroid or cortisone type drugs within the last year? ○ No ○ Yes
10. Do you take antibiotics prior to dental work of any other procedure? ○ No ○ Yes

C. Allergies

11. Are there medications to which you have had an allergic reaction or unpleasant side-effects?
○ No ○ Yes
(If yes, please describe in space below. If more than space allows, bring a list to your appointment)

Name of Medication	Reaction

12. Have you had an allergic reaction to any of the following? (specify all that apply)

○ Latex ○ Bee or wasp stings ○ Adhesive tape ○ Iodine or X-ray contrast dye
○ Influenza vaccination ○ Other (*Discuss with your care provider)* ○ None

13. Do you have any food allergies? ○ No ○ Yes (***if yes, please bring a list to your appointment)***

D. Systems Review

Fill in the circle to the left of each symptom that you have experienced in the past few months.
Indicate "NONE"(at the end of the list) if you nave not experienced any of the symptoms listed in each group

14.
○ fever
○ enlarged glands (lymph nodes)
○ breast lump
○ skin rash
○ skin sores
○ hoarseness
○ excessive bruising
○ change of a mole
○ significant headaches
○ seizures
○ slurred speech
○ excessive thirst
○ double vision
○ blurred vision
○ diminished hearing
○ dizziness
○ sinus problems
○ NONE

15. Are you bothered with:
○ shortness of breath
○ wheezing
○ coughing
○ NONE

16. Have you:
○ "blacked out" or lost consciousness
○ awakened at night with shortness of breath
○ been exposed to anyone with tuberculosis (TB)
○ coughed up sputum
○ coughed up blood
○ NONE

17. Have you had:
○ abnormal swelling in the legs or feet
○ pain in the calves of your legs when your walk
○ known difficulty with a heart valve
○ chest pain
○ chest pressure
○ NONE
○ irregular heart beats
○ rapid heart beats

Continue on next page …

Staff Initials ___________

Orthopaedic Surgery
& Sports Medicine
OF SAN ANTONIO

CURRENT VISIT/ MEDICAL HISTORY

18. Have you had:
- O difficulty swallowing
- O heartburn
- O nausea
- O vomiting
- O stomach trouble
- O significant problems with constipation
- O significant problems with diarrhea
- O blood in your bowel movements
- O changes in your bowel movements
- O excessive urination
- O burning or pain when urinating
- O difficulty starting your urinary steam
- O difficulty completely emptying your bladder
- O difficulty with leaking urine from your bladder
- O NONE

19. Have you had:
- O joint pain
- O joint stiffness
- O joint swelling
- O muscle pain
- O muscle stiffness
- O back pain
- O back stiffness
- O difficulty moving an arm or leg
- O NONE

20. Have you had:
- O weight gain of more than 10 pounds during the last 10 months
- O weight loss of more than 10 pounds during the last 10 months
- O NONE
- O problems with disruptive snoring
- O problems falling asleep
- O problems staying asleep
- O sleep apnea

Questions 20 to be completed by Female patients ONLY:

21. Number of pregnancies? **(please circle)**

1 2 3 4 5 6 7 8 9+

Number of live births? **(please circle)**

1 2 3 4 5 6 7 8 9+

Question 21 to be completed by MALE patients ONLY:

22. Have you had a vasectomy?

O No O Yes O Don't Know

E. Self Care/ Home Environment Assessment

23. What are your current living arrangements?

O House O Apartment O Nursing Home Assisted Living O Other

24. Do you live:

O Alone O With Spouse/Family O With others

25. Do you have family/friends or others who are able to provide assistance with your homecare needs if you would ever require such assistance?

O No O Yes

Continue on next page …

Staff Initials: ___________

Orthopaedic Surgery
& Sports Medicine
OF SAN ANTONIO

CURRENT VISIT/ MEDICAL HISTORY

F. Social History

26. How many years of school have you completed? Record highest level attained. **(please circle)**
1 2 3 4 5 6 7 8 9 10 11 12
13 14 15 16 17+

27. Are you currently married?
O No O Yes ***(If yes, indicate spouse's current employment status:)***
O Retired O Unemployed O Employed O Other
(homemaker,student,vounteer, etc.)

28. Have you been:
O Divorced O Widow/Widower In the past year? O No O Yes

29. What is your current employment status? Occupation:______________________
O Retired O Unemployed O Employed O Other
(homemaker,student,vounteer, etc.)

30. Are you disabled?
O No O Yes

G. Substance Review

31. Alcohol O NONE

	Number of days per week		Number of servings per day			Number of years used			
Current Use	0-2	3-7	1-2	3-4	5-10+	1-3	4-6	7-10	10+
Previous Use	0-2	3-7	1-2	3-4					

32. Cigarettes O NONE

	Number of days per week		Number of packs per day			Number of years used			
Current Use	0-2	3-7	1-2	3-4	5-10+	1-3	4-6	7-10	10+
Previous Use	0-2	3-7	1-2	3-4					

33. Other Tobacco O NONE

Number of years used	1-5	6-10	11-15	16-30	30+
Pipe					
Cigar					
Smokeless/Chew/Snuff					

H. Past Medical History

34. Have you ever traveled or lived outside the United States or Canada?
O Don't know O No O Yes

35. Have you ever received a blood transfusion?
O Don't know O No O Yes (***If yes, check all that apply)***
O Before 1980 O 1980-1990 O After 1990

Continue on next page …

Staff Initials: ___________

CURRENT VISIT/ MEDICAL HISTORY

Indicate whether you have ever sought medical care or had a medical problem or surgery related to each of the following. Indicate "No Problem" when appropriate. More than one answer may apply.

	NO PROBLEM	MEDICAL PROBLEM	SURGERY
Eyes	0	0	0
Ears	0	0	0
Nose	0	0	0
Sinuses	0	0	0
Tonsils	0	0	0
Thyroid or parathyroid gland	0	0	0
Arteries (heard arms legs, aorta, etc.)	0	0	0
Veins or blood clots in the veins	0	0	0
Heart attack	0	0	0
Heart valves	0	0	0
Abnormal heart rhythm	0	0	0
Narrowed coronary arteries	0	0	0
Pacemaker Placement	0	0	0
Lungs	0	0	0
Esophagus (food or swallowing pipe)	0	0	0
Diabetes	0	0	0
Stomach (ulcer)	0	0	0
HTN Hypertension/ high blood pressure	0	0	0
Asthma/ COPD	0	0	0
Bowel (small or large intestines, rectum)	0	0	0
Appendix	0	0	0
Lymph nodes	0	0	0
Spleen	0	0	0
Liver	0	0	0
Gallbladder	0	0	0
Pancreas	0	0	0
Hernia	0	0	0
Kidneys	0	0	0
Bladder	0	0	0
Bones (what type)	0	0	0
Muscles	0	0	0
Back	0	0	0
Neck	0	0	0
Brain	0	0	0
Breasts	0	0	0

Other

Continue on next page …

Staff Initials: ___________

CURRENT VISIT/ MEDICAL HISTORY

		NO PROBLEM	MEDICAL PROBLEM	SURGERY
Females:	Uterus	O	O	O
	Ovaries	O	O	O
	Fallopian tubes	O	O	O
	Hysterectomy	O	O	O
	Other	O	O	O
Male	Prostate	O	O	O
	Penis	O	O	O
	Testicles	O	O	O
	Vasectomy	O	O	O
	Other	O	O	O

I. Personal and Family History

36. Are you adopted? O No O Yes

37. If known, complete the following information about your blood relatives (include children).

Father
- O Don't know
- O Alive
- O Deceased - Age at death: O Under 30 O 30-40 O 41-50 O 51-60 O 61-70 O Over 70

Mother
- O Don't know
- O Alive
- O Deceased - Age at death: O Under 30 O 30-40 O 41-50 O 51-60 O 61-70 O Over 70

Brothers	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased	O	O	O	O	O	O	O	O	O

Sisters	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased	O	O	O	O	O	O	O	O	O

Sons	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased	O	O	O	O	O	O	O	O	O

Daughters	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased	O	O	O	O	O	O	O	O	O

Physician ______________________ Date ______________

Staff Initials __________