ASHLAND ORTHOPEDIC ASSOCIATES
CASE HISTORY

Answers to the following questions may be helpful in diagnosing and managing your health problems. These questions are general screening questions designed to identify areas where additional attention may be required. Feel free to provide additional details when needed. Thank you for your efforts.

Patient Name _____ Date Completed _____

Age _____ Sex: M F Marital Status: M S D W Height _____ Weight _____ Handedness: L R Both

What is the main reason for today's visit? _____

Primary Care Physician _____ Referring Physician _____

Occupation _____ Years of Education Completed _____

Recreation (frequency) _____

How would you rate your level of recreation on a scale of 0-10, with 0 being unable to be physically active, and 10 being that you are able to do all the physical activity you want to do?_____

Date of Accident (s) _____

Out of Work Days _____ Months _____ Years _____

Partial days missed from work due to your current medical problems: _____

PAST MEDICAL HISTORY (Circle **YES** or **NO** for any major significant illnesses which apply to you)

Anemia	YES	NO	Hay Fever/Sinus Problems	YES	NO
Asthma/Bronchitis/Emphysema	YES	NO	Heart Problems	YES	NO
Arthritis	YES	NO	Hepatitis	YES	NO
Bleeding/Bruising/Blood Disorder	YES	NO	High Blood Pressure	YES	NO
Cancer (type) _____	YES	NO	Immune Disorder	YES	NO
Depression	YES	NO	Kidney Disease	YES	NO
Diabetes			Liver Disease	YES	NO
Insulin Injection Dependent	YES	NO	Stroke	YES	NO
Non-Insulin Dependent	YES	NO			
Drug Abuse/Alcohol Dependency	YES	NO	Thyroid Disease	YES	NO
Epilepsy/Seizures	YES	NO	Tuberculosis (TB)	YES	NO
			Stomach Ulcers	YES	NO

Other (please describe)
INCLUDE CHILDHOOD ILLNESS _____

Please list previous hospitalizations, ALL surgeries, serious injuries, and approximate dates:

_____

_____

_____

_____

MEDICATIONS - List all medications you are taking and their dosages (prescription and all over-the-counter drugs)

ALLERGIES - List medication, food and environmental allergies and reaction type:

Have you had significant exposure to: Pesticides? YES NO Toxic Waste? YES NO

Have you had previous treatment with or exposure to Radiation? YES NO
If YES please explain: _____

FAMILY HISTORY

Some illnesses "run" in families. Please list health problems in your family.

	Age	Medical Problem	If Deceased - Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			
Grand-Parents			

SOCIAL HISTORY

Do you (or did you in the past) use tobacco? YES NO

Cigarettes: Packs per day_____ How many years_____ If you quit, when?_____

Other tobacco use: Amount per day_____ How many years_____ If you quit, when?_____

Do you drink alcohol? YES NO How often and how much?_____

Do you use any drugs other than prescribed or over-the-counter medications? YES NO

If so, please list _____

Do you eat a balanced diet? YES NO Is your weight stable? YES NO

Please indicate anything else of importance the Doctor should know about you: _____

Birthplace: _____ Relationship/Marital Status: _____

Who currently lives at home with you? _____

EXTENDED REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in any of the following areas?
Circle Y = Yes or N = No below. If "Yes", give an explanation.

	Yes	No	Patient Comments:	Physician Comments:
CONSTITUTIONAL				
Good general health lately	Y	N		
Recent weight changes	Y	N		
Recurrent fevers, chills, sweats	Y	N		
Fatigue	Y	N		
EYES				
Wear glasses/contact lenses	Y	N		
Blurred or double vision	Y	N		
Change in vision	Y	N		
Glaucoma	Y	N		
EARS / NOSE MOUTH / THROAT				
Change in hearing	Y	N		
Ringing in the ears	Y	N		
Recent nose bleeds	Y	N		
Chronic sinus problems	Y	N		
Mouth sores	Y	N		
Bleeding gums	Y	N		
Frequent sore throats	Y	N		
Voice changes	Y	N		
RESPIRATORY				
Asthma or wheezing	Y	N		
Breathing problems	Y	N		
Coughing up blood	Y	N		
Chronic cough	Y	N		
Pneumonia	Y	N		
CARDIOVASCULAR				
Heart trouble or heart attack	Y	N		
Chest pain or angina	Y	N		
Shortness of breath	Y	N		
Palpitations	Y	N		
Swelling of feet, ankles or hands	Y	N		
Blood clots	Y	N		
Varicose veins	Y	N		
GASTROINTESTINAL				
Change in appetite	Y	N		
Severe heartburn	Y	N		
Bleeding ulcers	Y	N		
Frequent nausea/vomiting	Y	N		
Vomiting blood	Y	N		
Frequent diarrhea	Y	N		
Constipation/painful bowel movements	Y	N		
Black or bloody stools	Y	N		
Rectal bleeding	Y	N		
Abdominal pain	Y	N		

	Yes	No	Patient Comments:	Physician Comments:
GENITOURINARY				
Blood in the urine	Y	N		
Burning with urination	Y	N		
Change in force of stream when urinating	Y	N		
Sexually transmitted disease	Y	N		
Change in sexual function or interest	Y	N		
Prostate trouble (men)	Y	N		
Scrotal masses (men)	Y	N		
Abnormal uterine bleeding (women)	Y	N		
Uterine tumors (women)	Y	N		
Pain/problems with periods (women)	Y	N		
NEUROLOGICAL				
Headaches	Y	N		
Numbness or tingling sensations	Y	N		
Weakness or paralysis	Y	N		
Convulsions or seizures	Y	N		
Change in memory or concentration	Y	N		
INTEGUMENTARY (Skin & Breasts)				
Birth marks	Y	N		
Recurrent rashes	Y	N		
Changing moles	Y	N		
Skin cancer or melanoma	Y	N		
Non-healing wounds	Y	N		
Breast pain or lump	Y	N		
Change in hair or nails	Y	N		
PSYCHIATRIC				
Memory loss or confusion	Y	N		
Nervousness	Y	N		
Depression	Y	N		
Change in sleep	Y	N		
Other	Y	N		
MUSCULOSKELETAL				
Joint stiffness or pain	Y	N		
Muscle pain or cramping	Y	N		
Weakness of muscles or joints	Y	N		
Back pain	Y	N		
Difficulty walking	Y	N		
ENDOCRINE				
Heat or cold intolerance	Y	N		
Excess thirst or urination	Y	N		
Thyroid problems	Y	N		
ALLERGIC / IMMUNOLOGIC				
Low resistance to infection	Y	N		
Recent cold or flu	Y	N		
Environmental allergies	Y	N		
Allergic reaction to medication	Y	N		
Tetanus booster within past 10 years	Y	N		
Other immunizations up to date	Y	N		
HEMATOLOGIC / LYMPHATIC				
Easy bruising	Y	N		
Frequent bleeding	Y	N		
Enlarged lymph nodes	Y	N		