

**Medical Information**

**Robert J. Ziets, MD, FAAOS**

*Complete BOTH SIDES of this form. Fill in or circle all items and write "N/A" where not applicable.*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date \_\_\_\_\_

**Primary Orthopedic Problem History**

**\*\*\*\*\*ONE PROBLEM ONLY!\*\*\*\*\***

*(If there are multiple problems, you must complete a SEPARATE FORM for each one.*

Which body part is involved? \_\_\_\_\_ Which side? (If Applicable) R L

When did the problem begin? Give date or estimate \_\_\_\_\_

If you know what caused the problem, explain \_\_\_\_\_

If you ever had a similar problem, explain what and when \_\_\_\_\_

Describe your current symptoms \_\_\_\_\_

What is your typical daily pain level?        0 1 2 3 4 5 6 7 8 9 10 (worst)

About how often you have symptoms? \_\_\_\_\_ Getting better or worse? \_\_\_\_\_

What movements or activities aggravate the problem? \_\_\_\_\_

**\*\*\*\*\* Complete the following items as related to THIS PROBLEM ONLY \*\*\*\*\***

Did you have MRI or CT scan?        Y\* N        \* If yes, did you bring the report(s)?    Y N

Did you have plain x-rays?        Y\* N        \* If yes, did you bring the films?        Y N

Are you taking pain medicine?        Y\* N        \* If yes, name(s) \_\_\_\_\_

Did you receive physical therapy?    Y\* N        \* If yes, are you currently enrolled?    Y N

Other tests or treatments?        Y\* N        \* If yes, details \_\_\_\_\_

Did you have surgery?        Y\* N        \* If yes, type and date \_\_\_\_\_

Did you see another orthopedic surgeon?    Y\* N        \* If yes, doctor's name \_\_\_\_\_

If there is any additional problem-specific information the doctor should know, explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*\*\*Please remember to bring all medical forms, x-rays and test results to your appointment and to present them to the medical assistant BEFORE you see Dr. Ziets.\*\*\*\*\***

**General Medical History**

Medical Conditions or Diagnoses (Current or Past)

*Check all that apply.*

None

- High Blood Pressure
- High Cholesterol
- Diabetes
- Coronary Disease
- Heart Valve Disease
- Arrhythmia
- Stroke
- Blood Clots / Emboli
- Leg Edema / Phlebitis
- Anemia
- Coagulopathy
- Cancer

- HIV
- Hepatitis C
- Tuberculosis
- Systemic Infection
- Bone/Joint Infection
- Gout
- Lupus
- Rheumatoid Arthritis
- Prednisone Use
- Osteoporosis
- Neurologic Disorder
- Skin Disease

- Tobacco Use
- Substance Abuse
- Anxiety / Depression
- Mental Illness
- Thyroid Disease
- Asthma
- Lung Disease
- Liver Disease
- Kidney Disease
- Digestive Disease
- Stomach Ulcers
- Other \_\_\_\_\_

Additional Details \_\_\_\_\_

\_\_\_\_\_

Past Surgical History

*List procedures with year (or estimate if not known).*

None

\_\_\_\_\_

\_\_\_\_\_

Current Medications

*List names of all; omit doses.*

None

\_\_\_\_\_

\_\_\_\_\_

Drug Allergies

*List names of all with type of reaction (if known).*

None

\_\_\_\_\_

\_\_\_\_\_