Medical Information

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 do 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? ☐☐ * If yes, did you bring the report(s)? ☐☐

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

Are you taking pain medicine? ☐☐ * If yes, name(s) _____

Did you receive physical therapy? ☐☐ * If yes, are you currently enrolled? ☐☐

Other tests or treatments? ☐☐ * If yes, details _____

Did you have surgery? ☐☐ * If yes, type and date _____

Did you see another orthopedic surgeon? ☐☐ * 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 and provide details.* □ None

□ High Blood Pressure
□ High Cholesterol
□ Diabetes
□ Coronary Disease
□ Heart Valve Disease
□ Arrhythmia
□ Stroke
□ Blood Clots / Emboli
□ Leg Edema / Phlebitis
□ Anemia
□ Bleeding Disorder
□ 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
□ Sleep Apnea
□ 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 or Latex Allergies *List names of all with type of reaction (if known).* □ None

_____

_____