UC San Diego
HEALTH SYSTEM

Orthopaedic Surgery
NEW PATIENT INFORMATION

Patient Identification

Who referred you to our office? Name/Address/Phone/ Speciality:

____

____

Is there anyone else you would like to receive information about your orthopedic care?

____

____

Why are you being seen today? ❑ Right Side ❑ Left Side ❑ Both Sides

Please describe your current orthopedic problem/injury (how it started symptoms, etc):

____

____

____

Date of onset (or approximate duration of the problem if onset was gradual): ____________________

Circle the number that best represents your average pain level over the last week: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
Circle the number that best represents your overall disability/dysfunction level: (No dysfunction) 0 1 2 3 4 5 6 7 8 9 10 (wheelchair/bedbound)

Check all that apply

Pain Quality: ❑ Sharp ❑ Aching ❑ Stabbing ❑ Throbbing ❑ Burning/tingling

Associated Symptoms: ❑ Swelling ❑ Locking/catching ❑ Instability/giving way ❑ Stiffness

Timing of Pain: ❑ Morning ❑ Night ❑ Worse as day goes on ❑ Activity-related

❑ With walking/standing ❑ With running/exercise ❑ Gets better with activity, or as day goes on

❑ Start-up pain (worse with first few steps after sitting/resting)

Have you ever had a similar pain/problem in the past? ❑ Yes ❑ No

What makes it better? ______________________________

What makes it worse? ______________________________

Prior treatment: ❑ Rest ❑ Cane/Crutches/Walker ❑ Orthotics/Shoe inserts/Pads

❑ Night splint ❑ Brace (#wks, type?)____________________ ❑ Boot (# wks): _________

❑ Cast (# wks): _______ ❑ Physical Therapy (#wks): _______ ❑ Other: ______________

Medication (name/dose/duration): ______________________________

Injections (How many? % Improvement, duration?) ______________________________

Prior Surgery for this problem or body part (who/where/when/what): ____________________

____

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Check all that apply

Past Medical History: ❑ High Blood Pressure ❑ Heart Failure ❑ Heart Attack/MI
❑ Atrial Fibrillation ❑ High Cholesterol ❑ Diabetes ❑ Thyroid Disorder ❑ Asthma
❑ Chronic Bronchitis ❑ Emphysema/COPD ❑ Pneumonia ❑ Tuberculosis ❑ Sleep Apnea
❑ Blood Clots ❑ Pulmonary Embolism ❑ Liver Disorder ❑ Hepatitis (type): _______
❑ GERD/Reflux ❑ Stomach Ulcer ❑ Ulcerative Colitis/Crohns ❑ Kidney Stones
❑ Kidney Failure/Dialysis ❑ Polio ❑ Neuropathy ❑ Charcot-Marie-Tooth ❑ Seizure Disorder
❑ Stroke/TIA ❑ Cataracts ❑ Glaucoma ❑ Gout ❑ Psoriasis ❑ Lupus/SLE ❑ Osteoarthritis
❑ Rheumatoid Arthritis ❑ Lyme disease ❑ HIV/AIDS ❑ Osteoporosis ❑ Depression
❑ Anxiety ❑ Fibromyalgia ❑ Cancer (specify)_______________________________________
❑ Other (specify) ____

Are you/could you be pregnant? ❑ Yes ❑ No

Past Surgical History (List ALL surgeries - example: appendix, tonsils, etc., and date of surgery)

____

____

____

Anesthesia Problems? ❑ No ❑ Yes, describe: ______________________________________

Check all that apply

Family History: ❑ Diabetes ❑ Heart Disease ❑ Blood Clots/Pulmonary Embolism
❑ Major Anesthesia Problems ❑ Charcot-Marie-Tooth ❑ Cancer (type): ____________________
Other: ____

Social History: **Occupation:** ____
❑ Student ❑ Homemaker ❑ Retired ❑ Unemployed ❑ On Disability

With whom do you live? ❑ Mother ❑ Father ❑ Spouse ❑ Partner ❑ Children ❑ Siblings
❑ Roomate/s ❑ Alone

Exercise: ❑ Never ❑ Rarely/Monthly ❑ Weekly ❑ Daily
What type of exercise? ____

Hobbies: ____

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Do you smoke? ❑ No ❑ Yes ❑ Quit (when?) ________________
What is the most you have ever smoked on a regular basis? ______________________________
How many years have you/ did you smoke in your life? ______________________________
Do you drink alcohol? ❑ No ❑ Yes ❑ Quit (when?) ________________
How much do you drink per week? ______________________________
Recreational drugs? Current use: ❑ Yes ❑ No Past use: ❑ Yes ❑ No
What type? ______________________________

Check all that apply

Review of Systems: Hematologic: ❑ Anemia ❑ Bleeding Tendency ❑ Easy Bruising
Constitutional: ❑ Fevers ❑ Chills ❑ Night Sweats Unplanned: ❑ Weight Gain ❑ Weight Loss
Cardiovascular: ❑ Chest Pain ❑ Palpitations ❑ Heart Murmur ❑ Swollen Legs ❑ Leg Cramps
Pulmonary: ❑ Chronic Cough ❑ Wheezing ❑ Shortness of Breath
GI: ❑ Nausea/Vomiting ❑ Constipation ❑ Chronic Diarrhea ❑ Blood in Stool
GU: ❑ Incontinence ❑ Problems Urinating **Endocrine:** Intolerance of ❑ heat ❑ cold
Eyes: ❑ Double Vision ❑ Blindness **Head/Neck/Ears:** ❑ Deafness ❑ Sinus Problems
Neurologic: ❑ Frequent Headaches ❑ Dizziness ❑ Balance Problems ❑ Numbness/Tingling
❑ Weakness **Skin:** ❑ Ache ❑ Rash **Immunologic:** ❑ Swollen Glands ❑ Hay fever
Musculoskeletal: ❑ Stiffness ❑ Joint Pain ❑ Joint Swelling ❑ Neck or Back Problems
GYN: ❑ Menstrual Problems ❑ Breast Masses **Psychiatric:** ❑ Anxiety ❑ Depression
Other: ______________________________

Please write all ALLERGIES and all MEDICATIONS (including non-prescription meds and supplements) on the separate form provided.

This information is correct to the best of my knowledge.

Patient Signature: ______________________________ **Date/Time:** ________________

I have reviewed this new patient history form, including the list of allergy and medications

______________________________ ________________

Physician Signature/PID# **Date/Time**