Date:___ / ____ / ______

BocaCare Orthopedics

Patient Health Information

Patient Name:____ Age:______________

Reason for Visit:____

Sex: Male or Female Dominant Hand (Circle): Right or Left

List Contributing Events of Cause of Symptoms:_______________________________________

____

Duration of Symptoms / Date of Injury: ____

Do you have pain? Yes or No Severity of pain (1 least, 10 most) : 1 2 3 4 5 6 7 8 9 10

Frequency of Pain: ____Constant ____Intermittent ____Progressive _____Not Progressive _____Improving

Character of Pain: ____Sharp ____Dull ____Burning ____Stabbing ____Numbness ____Pins/Needles

Additional Symptoms (Circle): Swelling Weakness Decreased Range of Motion Locking
Popping Clicking Instability / Giving Way

What Activities Worsen your Condition? ____

Past Treatment for Current Problem? ____ Ice ____Heat ____Rest ____Physical Therapy ____Injections

Medications for Current Problem (Include all medications tried and currently taking): _______________

____

Surgeries for Current Problem (Include Dates):_______________________________________

PAST MEDICAL HISTORY: (Please circle Yes or No to all questions)

Yes No ALCOHOLISM
Yes No ANEMIA
Yes No ARTHRITIS (Location) ____________________
Yes No ASTHMA
Yes No BLOOD CLOTS
Yes No BLOOD DISEASES ____________________
Yes No BLOOOD TRANSFUSION (When) ____________
Yes No BRONCHITIS
Yes No CANCER (Type) ____________________
Yes No CATARACTS
Yes No COLITIS
Yes No COPD (Chronic Obstructive Pulmonary Disease)
Yes No DIABETES TAKING INSULIN? Yes No
Yes No DIVERTICULITIS
Yes No DRUG ADDICTION
Yes No EMPHYSEMA
Yes No EPILEPSY
Yes No ECZEMA
Yes No FRACTURES/BROKEN BONES
Location:______________________________
Yes No GASTRIC REFLUX
Yes No GOUT
Yes No GLAUCOMA
Yes No HEPATITIS (If Yes Circle Type): A B C E
Yes No HERNIA (If Yes Circle Type):
Inguinal Hiatal Ventral

Yes No HEART DISEASE _____ Mitral Valve Prolapse
____ Murmurs ____ Congestive Heart Failure
____ Abnormal Rhythm ____ Cardiac Stents
____ Heart Attack (MI) How many? __________
Yes No HIGH BLOOD PRESSURE (Hypertension)
Yes No HIGH CHOLESTEROL
Yes No HIV POSITIVE Current CD4 Count?:__________
Yes No KIDNEY STONES
Yes No KIDNEY DISEASE (Type):_______________
Yes No LATEX ALLERGY
Yes No LIVER CIRRHOSIS (Cause?):______________
Yes No OSTEOPOROSIS
Yes No PARKINSON'S
Yes No PEPTIC ULCERS
Yes No PERIPHERAL VASCULAR DISEASE:
_____Arterial _____Venous _____Both
Yes No BENIGN PROSTATIC HYPERTROPHY (BPH)
Yes No PROSTATE INFLAMMATION
Yes No PSORIASIS
Yes No RASH (Type):_____________________
Yes No STROKE
Yes No SEASONAL ALLERGIES
Yes No THYROID DISEASE
OTHER:______________________________________

____

Patient Name:______________________________ Date:______________

PAST SURGICAL HISTORY: (Please circle Yes or No to all questions and write date of procedure)

Yes No APPENDECTOMY
Yes No ARTHROSCOPY (Joints?):______________
Yes No BACK SURGERY
Yes No NECK SURGERY
Yes No BREAST SURGERY
Yes No CATARACT SURGERY
Yes No CARPAL TUNNEL RELEASE
Yes No CESAREAN SECTION
Yes No D & C
Yes No GALLBLADDER SURGERY
Yes No JOINT REPLACEMENT (Location):__________
____
Yes No OTHER ORTHOPEDIC SURGERIES: __________
____

Yes No HEART BYPASS
Yes No HEART VALVE REPLACEMENT
Yes No HEART STENTS (How Many?):__________
Yes No HERNIA REPAIR
Yes No HYSTERECTOMY
Yes No TUBAL LIGATION
Yes No KIDNEY SURGERY
Yes No LITHOTRIPSY (Kidney Stone Removal)
Yes No PACEMAKER (Type:)?______________
Yes No PROSTATE SURGERY
Yes No SKIN CANCER SURGERY
Yes No TONSILLECTOMY
Yes No OTHER SURGERIES: ______________
____

MEDICATION ALLERGIES? No or Yes (If yes list medication and reaction):______________
____

LIST OF YOUR CURRENT MEDICATIONS: (If None, write 'None' in the first box)

Drug Name & Strength	Dose	Frequency	Indication

Patient Name: ______________________________ Date: ______________

FAMILY HISTORY: (List Medical Conditions for Each, if deceased write 'deceased' and list cause if known)

FATHER'S HEALTH: ____ Good ____ Fair ____ Poor ______________________________

MOTHER'S HEALTH: ____ Good ____ Fair ____ Poor ______________________________

SIBLING'S HEALTH: ____ Good ____ Fair ____ Poor ______________________________

SOCIAL HISTORY:

PREFFERED LANGUAGE: ______________ LANGUAGES SPOKEN: ______________

ETHINICITY (Circle): NON HISPANIC HISPANIC

RACE: _____ American Indian / Alaskan Native _____ Asian _____ Black/African American _____ Declined

_____ Native Hawaiian / Pacific Islander _____ White

ALCOHOL USE? _______ None or ______ Yes (List Number of Drinks / Day or Week): ______________

TOBACCO USE? _______ Never or ______ Prior Smoker (How long ago did you quit?): ______________

_______ Current Smoker (Amount currently smoking in packs/day): ______________

At what age did you start smoking? _________

CURRENT OR FORMER OCCUPATION: ______________________________

CURRENTLY EMPLOYED? Yes No RETIRED? Yes No

STUDENT? Yes No GRADE: ______________ SCHOOL: ______________

HOBBIES / ACTIVITIES: ______________________________

REVIEW OF SYSTEMS: (Please circle yes or no to all questions)

Yes No Fever or Chills
Yes No Headaches
Yes No Hearing loss
Yes No Chest Pain
Yes No Heart Murmur
Yes No Irregular heart beat
Yes No Difficulty breathing
Yes No Shortness of breath
Yes No Prior problems with Anesthesia
Yes No Jaw or tooth pain while eating (odynophagia)
Yes No Bloody Stools
Yes No Bloody Urine
Yes No Urinary Retention

Yes No Rash
Yes No Itching
Yes No New skin lesions
Yes No Numbness / Tingling
Yes No Seizures
Yes No Cold intolerance
Yes No Heat intolerance
Yes No Anxiety
Yes No Depression
Yes No Easy bleeding
Yes No Easy bruising
Yes No Lymph node enlargement / tenderness

Height: ______ feet ______ inches **Weight: ______ lb or ______ kg**

PRIMARY CARE PHYSICIAN(PCP): ______________________________ Phone: ______________

Address: ______________________________

Who recommended or referred you to this office? (Please provide person's name and contact info if known)

____

BOCACARE
ORTHOPEDICS