UK HealthCare
Orthopaedic Surgery
& Sports Medicine

NEW PATIENT/INJURY MEDICAL FORM

Name:____________________________________Date:_____________________Birthdate:__________________________

Gender: Male Female Occupation:_____________________________Athlete/School:____________________________

What physician or other health care professional sent you to us? ____

Please explain your problem in one sentence____

What body part is involved? ☐R ☐L ___________When did it start? _____Days ____Weeks ____Months ____Years

What are your expectations today? ☐Explanation or Diagnosis ☐Tests ☐Medicines
☐Therapy ☐Injection ☐Schedule surgery

Check the **ONE box** that best describes how your problem started:

☐**NO INJURY- onset was ____Gradual ____Sudden** Why do you think it started?________________________

☐**INJURY- ____Accident ____Sport** Date of injury__________Sport?____________School?______________

☐**WORK RELATED** Date of Injury/Pain_____________How? ____

☐**AUTO ACCIDENT Date**___________________

On a scale of 0-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

Check the ones that describe your pain: ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning

The pain is: ☐Constant ☐Come and goes Does your pain wake you from your sleep? ☐Yes ☐No

Since your problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged

What makes your symptoms worse? ☐Standing ☐Walking ☐Running ☐Getting Up ☐Stairs ☐Twisting ☐Kneeling
☐Squatting ☐Lifting ☐Reaching ☐Gripping

What medications are you taking now (or previously) for this problem? ___________________________________

Have you had any of these treatments? ☐Injection ☐Brace ☐Physical Therapy ☐Crutches

What tests/scans have you had for this problem? ☐X-ray ☐MRI ☐CAT scan ☐Bone Scan ☐Nerve test (EMG/NCV)

Have you had surgery for this problem? ☐Yes (list below) ☐No

Surgery Date(s)/Physician(s)/Procedure(s):____

Current Work status: ☐Regular ☐Light duty (how long_____________) ☐Not working due to problem ☐Disabled
☐Retired ☐Student

When is the last date you worked your regular job? ____

Are you currently receiving or plan to apply for: ☐Disability ☐Workmen's Comp ☐Unemployment

List Doctors who have treated you- Include Name/Specialty/City/Date

____

FORM CONTINUED ON BACK

UK HealthCare Orthopaedic Surgery & Sports Medicine

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MEDICAL HISTORY: Please check if **you** have any of the following:

High blood pressure ☐ Diabetes ☐ Stroke ☐
Heart disease ☐ Cancer ☐ Respiratory Problems ☐
Bleeding problems ☐
Allergies ☐(List)____________________
Other ☐(List)____________________
Current Medications:____________________
Past hospitalizations/surgeries/injuries and approximate dates:____________________

Please check if any of your relatives ever had any of the following problems- indicate who:

Heart disease ☐ Who:__________ High blood pressure ☐ Who:__________
Diabetes ☐ Who:__________ Stroke ☐ Who:__________
Cancer ☐ Who:__________ Thyroid disease ☐ Who:__________

SOCIAL HISTORY:

Marital status: ☐single ☐married ☐separated ☐divorced ☐widowed
Tobacco use: ☐never ☐quit-when__________ ☐smoker/pack per day_____
Alcohol use: ☐never ☐rarely ☐moderate ☐daily
Drug use: ☐never ☐type and frequency__________

REVIEW OF SYSTEMS

Constitutional
☐Good General Health
☐Recent weight change
☐Night sweats, fevers
☐Fatigue

Ears/Nose/Mouth/Throat
☐Hearing loss or ringing
☐Sinus problems
☐Nose bleeds
☐Sore throat/voice change

Eyes
☐Wear glasses/contacts
☐Blurred/double vision
☐Eye disease or injury
☐Glaucoma

Cardiovascular
☐Chest pain
☐Palpitations
☐Heart trouble
☐Swelling hands/feet

Respiratory
☐Shortness of breath
☐Cough
☐Wheezing/asthma
☐Coughing up blood

Gastrointestinal
☐Nausea/vomiting
☐Abdominal Pain
☐Rectal Bleeding
☐Bowel problems

Musculoskeletal
☐Muscle pain or cramps
☐Stiffness/swelling in joints
☐Joint pain
☐Trouble walking

Neurological
☐Frequent headaches
☐Paralysis or tremors
☐Convulsions/seizures
☐Numbness/tingling

Integumentary (Skin/Breast)
☐Change in hair/nails
☐Rashes or itching
☐Breast lump
☐Breast pain or discharge

Endocrine
☐Excessive thirst/urination
☐Thyroid disease
☐Hormone problem

Hematologic/Lymphatic
☐Bruise easily
☐Slow to heal
☐Enlarged glands

Allergic/Immunologic
☐Food allergies
☐Aspirin allergies
☐Antibiotic allergies

Genitourinary – Male only
☐Blood in urine
☐Kidney stones
☐Sexual problems
☐Testicle pain

Genitourinary-Female only
☐Blood in urine
☐Kidney stones
☐Sexual problems
☐Menstrual pain

Psychiatric
☐Insomnia
☐Confusion/memory loss
☐Depression

Patient Statement: To the best of my knowledge, the above information is accurate.

Physician Statement: I have reviewed the questionnaire with the patient. All systems reviewed with pertinent positives noted by check boxes. All other systems were reviewed and found to be negative.

Signed:____________________Date:____________________