Monadnock Orthopaedic Associates – Review of Symptoms

Patient's Name: _____

(Please circle if you currently have any of the following:)

CONSTITUTIONAL **- Fever** **- Night sweats** **- Significant weight gain or weight loss** **- Exercise intolerance**	**MOUTH/THROAT** **- Sore throat** **- Bleeding gums** **- Snoring** **- Dry mouth/Ulcers** **- Other oral abnormalities** **- Teeth problems**	**GENITOURINARY** **- Urinary loss of control** **- Difficulty urinating** **- Increased urinary frequency** **- Hematuria** **- Incomplete emptying**	**PHYSIATRIC** **- Depression** **- Sleep disturbances** **- Restless sleep** **- Feeling unsafe in relationship** **- Alcohol abuse**
EYES **- Dry eyes** **- Eye irritation** **- Vision change**	**CARDIOVASCULAR** **- Chest pain** **- Arm pain on exertion** **- Shortness of breath when walking, shortness of breath when lying down** **- Palpitations** **- Known heart murmur**	**MUSCULOSKELETAL** **- Muscle aches** **- Muscle weakness** **- Arthralgias/joint pain** **- Back pain, swelling in the extremities**	**ENDOCRINE** **- Fatigue** **- Increased thirst** **- Hair loss** **- Increased hair growth** **- Cold intolerance**
ENMT **- Difficulty hearing** **- Ear pain**	**RESPIRATORY** **- Cough** **- Wheezing** **- Shortness of breath** **- Coughing up blood**	**INTEGUMENTARY** **- Abnormal mole** **- Jaundice** **- Rash/Itching/Dry Skin** **- Growth/lesion**	**HEMATOLOGIC/LYMPHATIC** **- Swollen glands** **- Easy bruising** **- Excessive bleeding**
NOSE **- Frequent nose bleeds** **- Nose/sinus problems**	**GASTROINTESTINAL** **- Abdominal pain** **- Vomiting** **- Change in appetite** **- Black/tarry stools** **- Frequent diarrhea** **- Vomiting blood**	**NEUROLOGIC** **- Loss of consciousness** **- Weakness/Numbness** **- Seizures/Dizziness** **- Frequent or severe headaches or Migranes** **- Restless legs**	**ALLERGIC/IMMUNOLOGIC** **- Runny nose** **- Sinus pressure** **- Itching** **- Hives** **- Frequent sneezing**

Medical History

Have you ever had, or do you have, a history of: (Circle YES responses)

Heart Problems	**High Blood Pressure**
Heart Attack	**Diabetes Type I or II**
Angina/Chest Pain	**Cholesterol/Lipids**
CHF/Congestive Heart Failure	**Thyroid Problems**
Stroke/TIA	**Osteoporosis/Thin Bones**
Neurological Problems	**Osteoarthritis**
Epilepsy/Seizures	**Rheumatoid (Inflammatory) Arthritis**
Stomach Ulcers	**Other Orthopaedic Conditions**
Gastric Reflux	**Problems with Anesthesia**
Cancer	**Lung Problems**
Liver Disease/Hepititis A-B-C	**COPD**
Kidney Problems	**Asthma**
Anxiety/Depression	**Sleep Apnea**
Blood/Bleeding Disorder	**Other Medical Issues: List below**

Surgical History – Have you had surgery for any of the following:

(Circle YES responses and include approximate dates, if known)

Abdominal	**Hernia Repair**	**Prostate**
Appendix	**Hysterectomy**	**Tonsil/Adenoids**
Bladder	**Lung**	**Transplant**
Cancer	**Nasal/Oral**	**Tubes/Vasectomy**
Cardiac	**Orthopaedic**	**Vascular**
Gallbladder	**Plastic Surgery**	**Other - List below:**
GYN	**Prior Anesthesia Reactions**	

Family History

Please circle any items below pertaining to your family and indicate which relationship has/had this medical issue. Family members are listed in box below:

Anxiety or Depression	GERD	Neurological Problems	Stomach Ulcers
Blood or Bleeding Disorder	Heart Problems	Osteoarthritis	Stroke/TIA
Cancer	Hepatitis A-B-C or Liver Problems	Osteoporosis/Thin Bones	Sugar Diabetes Type 1 or 2
Early Cardiac Disease (before age 50)	High Blood Pressure	Problems with Anesthesia	Thyroid Problems
Epilepsy or Seizures	Kidney Problems	Rheumatoid (inflammatory) Arthritis	Total Joint Replacement
	Lung Problems, COPD, Asthma	Sleep Apnea	

Relationship: Mother, Father, Brother, Sister, Son, Daughter

Social History

Please circle and/or fill in your social history below:

Occupation:	Alcohol Intake: none occasional moderate heavy
Hand Dominance: L R	Alcohol Amount Consumed:
Highest Level of Education: High School 2-years of College 4 Years of College, Masters Doctorate	Smoking Status: non-smoker smoker past-smoker/quit
Marital Status: Single Married Divorced Widowed	Smoking: How Much – 1 PPW, 2 PPW, ¼ PPD, ½ PPD, 1 PPD, 2 PPD, 3+ PPD
Living Status: Alone With Others	# Years Smoked:
Type of Home: Single Multi-level	Quit Smoking: Indicate Date:
Sporting Activities:	Recreational Drug Use: Yes No
Hobbies/Avocational Activities:	

History of Present Illness (HPI)

For your visit TODAY, please complete this information about your problem:

Body Part: _____

Location of pain: Left, right, bilateral,

Describe the Pain: aching, burning, gnawing, stabbing, throbbing, sharp, dull, superficial, deep, occasional, frequent, constant, worsening, improving, not changing

Severity: no pain, mild, moderate, severe, pain level ___/10, worst pain ____/10

Duration: date of onset:_____, # of days ____, # of weeks, _____ # of months, _____ # of years_____

When does your pain occur: cannot identify, acute, chronic, abrupt, gradual, morning, daytime, night time, recurrent, rare, occasional, intermittent episodes lasting _____

How did this happen: cannot identify, fall, bending, lifting, twisting, sports injury, work injury, MVA, assault, overuse, laceration

What IMPROVES the pain? nothing helps, sitting, standing, lying down, position change, heat, ice, rest, elevation, exercise, stretching, limited weight bearing, PT/OT, chiropractic care, OTC medication, narcotics, NSAIDs, cortisone injection, orthotics, previous surgery, brace, crutches, cane, wheelchair, walker

What AGGRAVATES the pain? cannot identify, sitting, standing, lying down, walking, lifting, carrying, twisting, bending/squatting, pushing/pulling, throwing, ROM, weight bearing, exercise, previous surgery, changing clothes, getting out of bed, going from sit to stand, upstairs, downstairs, morning, daytime, nighttime, cold weather, damp weather

Have you had any of these associated symptoms? weakness, numbness, tingling, swelling, redness, warmth, catching/locking, popping/clicking, buckling, grinding, instability, radiation of pain, drainage, fever, chills, weight loss, change in bowel/bladder habits

Previous Surgery: none surgical procedure:_____ date:_____

Prior Imaging: none, no recent studies, x-ray, MRI, CT scan, bone scan, EMG

Previous Injections: none, did not help, helped a little, helped temporarily, helped significantly

Previous PT: none, did not help, helped temporarily, helped significantly

Work Related: Yes No **Working:** no, yes- regular duty, yes-modified duty