ALEXANDER ORTHOPAEDIC ASSOCIATES
HISTORY & PHYSICAL

Room # _____
Provider _____
X-ray taken _____
XR/MRI brought yes no
Facility _____
(for office use only)

TODAY'S DATE: _____

PATIENT NAME: _____ **Age:** _____ **DOB**: _____

(please circle): **M** **F** Right handed Left handed **HEIGHT:**_____ **WEIGHT:** _____ **BLOOD PRESSURE:**_____

RACE/ETHNICITY (please circle): **WHITE** **HISPANIC** **AFRICAN AMERICAN** **PACIFIC ISLANDER** **OTHER** _____

PRIMARY CARE_____

PREFERRED LANGUAGE (please circle): **ENGLISH** **SPANISH** **OTHER** _____

TODAYS CHIEF COMPLAINT (what body part are you seeking treatment for) _____ □ right □ left

HISTORY OF PRESENT ILLNESS OR INJURY (when and how did it happen):

EXACT DATE PAIN BEGAN OR INJURY OCCURRED _____

HOW WERE YOU INJURED? □ IN A SPORT □ ACCIDENT □ AUTO ACCIDENT □ NEITHER
WERE YOU INJURED AT WORK? □ YES □ NO **IF YES, WHAT DATE WERE YOU INJURED?**_____

HOW LONG HAVE YOUR SYMPTOMS BEEN PRESENT? _____
ON A SCALE OF 1-10, HOW SEVERE IS YOUR PAIN? _____
WHAT MAKES YOUR SYMPTOMS WORSE? _____
WHAT MAKES YOUR SYMPTOMS BETTER? _____

PREVIOUS INJURY TO THIS AREA: (please circle) **Y** **N**
If yes, explain:

CURRENT MEDICATIONS (name, strength and dose):

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

7._____ **8.**_____ **9.**_____

PAST MEDICAL HISTORY: (please check all that apply)

Arthritis
Asthma
Bleeding Disorders/Blood Clots
Cancer
COPD
Diabetes
GERD
GI Disorders
Heart Attack
Hepatitis A, B, or C
High Blood Pressure
High Cholesterol
HIV/AIDS
Liver Disease
Neurological Disorders
Other
Osteoporosis
Pacemaker
Renal Disease
Rheumatoid Arthritis
Stroke
Thyroid Disease

PATIENT NAME: _____

ALLERGIES (please circle): **Aspirin Codeine Latex Penicillin Sulfa None Other:** _____
Reaction: _____

LIST ALL PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: □ NONE

1. _____ YEAR _____
2. _____ YEAR _____
3. _____ YEAR _____
4. _____ YEAR _____
5. _____ YEAR _____

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative
□Diabetes _____ □High Blood Pressure _____ □Rheumatoid Arthritis _____
□Difficulty with anesthesia_____ □Bleeding Problems_____ □None known

SOCIAL HISTORY (please circle): **Smoking** Qty_____ **Drinking** Qty_____ **Drugs** Type/Qty_____

MARITAL STATUS (please circle): **Single Married Divorced Widow Separated Student**

EMPLOYMENT STATUS (please circle): **Employed Unemployed Disabled Retired Occupation _____**

REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE				**NONE**	**YEAR**	**Details/Comments**
1. **GI**	□Heartburn, Ulcers	□Nausea, Vomiting	□Blood in Stool	□	____	_____
2. **ENDO**	□Thyroid Disease	□Heat or Cold Intolerance		□	____	_____
3. **CON**	□Weight Loss	□Loss of Appetite	□Fatigue	□	____	_____
4. **EYE**	□Blurred Vision	□Double Vision	□Vision Loss	□	____	_____
5. **ENT**	□Hearing Loss	□Hoarseness	□Trouble Swallowing	□	____	_____
6. **CV**	□Chest Pain	□Palpitations		□	____	_____
7. **RS**	□Chronic Cough	□Pneumonia	□Shortness of Breath	□	____	_____
8. **GU**	□Painful Urination	□Blood in Urine	□Kidney Problems	□	____	_____
9. **SK**	□Frequent Rashes	□Skin Ulcers	□Lumps □Psoriasis	□	____	_____
10. **NEU**	□Headaches	□Dizziness	□Seizures □Numbness	□	____	_____
11. **PSY**	□Depression/Anxiety	□Drug/Alcohol Addiction	□Sleep Disorder	□	____	_____
12. **HEM**	□Easy Bleeding	□Easy Bruising	□Anemia	□	____	_____

13. **Are you HIV Positive?** □Yes □No

Have you ever had Hepatitis A, B, or C? □Yes □No If yes what type? _____

14. **Are you pregnant?** □Yes □No
15. **Are you Claustrophobic?** □Yes □No

PHARMACY NAME _____
ADDRESS/CROSS STREETS _____
PHONE# _____

Patient Assessment

The physicians at Alexander Orthopaedic Associates are concerned about your orthopaedic health and want to make sure that we are evaluating those factors which may impact your orthopaedic wellbeing. The following questions are intended to give the physicians at Alexander Orthopaedic Associates information about your general health.

Please check the correct answer or fill in the blanks.

1. What is your height _____ weight _____ Prefer not to answer _____

2. Have you had a Bone Density Study (also known as a Dexa scan) for osteoporosis at least once since age 60?
Yes _____ No _____
If yes, in what year did you have the most recent Bone Density Study? _____

3. Have you been on medicine to treat osteoporosis? **Yes _____ No _____**

If yes, has it been prescribed within 12 months? **Yes _____ No _____**
What medicine are you taking to treat your osteoporosis? _____

4. Do you take Calcium and Vitamin D? **Yes _____ No _____**

5. Have you ever had a fracture of your arm, hip, or spine? **Yes _____ No _____**

6. Have you fallen more than twice or fallen and hurt yourself in the past year? **Yes _____ No _____**

7. Have you had the influenza vaccination for the current flu season? **Yes _____ No _____**

8. Have you ever had the pneumococcal vaccine? **Yes _____ No _____**

9. Do you have an Advanced Care Plan? **Yes _____ No _____**

10. Have you used or smoked tobacco products in the last 24 months? **Yes _____ No _____**
If yes, are you a tobacco smoker? **Yes _____ No _____**

11. Do you consume alcoholic beverages? **Yes _____ No _____**
If yes, how much per setting? _____ Per week? _____

Please understand that smoking and consuming alcoholic beverages can impair your general health as well as your orthopaedic health.

Are you interested in quitting? **Yes _____ No _____**

Print name: _____

Patient signature: _____

Date: _____