TOTAL JOINT SPECIALISTS

Name:_____ DOB: _____

Height: _____ Weight: _____ Work Injury: ☐ Y ☐ N Current Occupation:_____

Have you seen another physician regarding this condition? ☐ Y ☐ N If Yes, List name & dates seen _____

_____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY OR HAVE APPLIED) ☐ NO PAST MEDICAL HISTORY

CARDIAC
- ☐ A-FIB
- ☐ CORONARY ARTERY DISEASE (CAD)
- ☐ CONGESTIVE HEART FAILURE (CHF)
- ☐ HEART ATTACK (MI)
- ☐ HEART MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL

PULMONARY
- ☐ ASTHMA
- ☐ COPD
- ☐ EMPYHSEMA
- ☐ BRONCHITIS
- ☐ SLEEP APNEA/CPAP
- ☐ BIPAP

ENDOCRINE
- ☐ DIABETES
- ☐ GOUT
- ☐ OBESITY
- ☐ THYROID PROBLEMS

MUSCULOSKELETAL
- ☐ FIBROMYALGIA
- ☐ LUPUS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPENIA
- ☐ OSTEOPOROSIS
- ☐ RHEUMATOID ARTHRITIS

DERMATOLOGY
- ☐ PSORIASIS

INFECTIOUS DISEASE
- ☐ AIDS/HIV
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ MRSA
- ☐ TUBERCULOSIS (TB)

GASTROINTESTINAL
- ☐ GERD/ACID REFLUX
- ☐ PEPTIC ULCER DISEASE (GASTRIC ULCERS)
- ☐ HERNIA

CANCER
- ☐ CANCER
  TYPE:_____

NEUROLOGICAL
- ☐ STROKE/TIA
- ☐ SEIZURE DISORDER
- ☐ PARKINSON'S DISEASE
- ☐ ALZHEIMER'S DISEASE
- ☐ SPINAL CORD INJURY

GENITOURINARY
- ☐ KIDNEY DISEASE
- ☐ KIDNEY OR BLADDER STONES

HEMATOLOGY/VASCULAR
- ☐ BLEEDING DISORDERS
- ☐ DVT/BLOOD CLOTS
- ☐ PULMONARY EMBOLISM
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ SICKLE CELL ANEMIA

REPRODUCTIVE: Are you pregnant? ☐ Y ☐ N Last Menstrual Period_____ Are you currently breastfeeding ☐ Y ☐ N

IMMUNIZATION STATUS: Is your immunization status current? ☐ Yes ☐ No ☐ Unknown

METALLIC IMPLANTS: What and where? _____

REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY)

CONSTITUTIONAL
- ☐ FATIGUE
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

HEENT
- ☐ BLIND/VISUAL IMPAIRED
- ☐ DENTAL PROBLEMS
- ☐ DENTURES
- ☐ GINGIVITIS/GINGIVAL BLEEDING
- ☐ GLASSES OR CONTACTS
- ☐ HEADACHE
- ☐ HEARING AID
- ☐ SINUS PROBLEMS

PULMONARY
- ☐ COUGH
- ☐ SHORTNESS OF BREATH

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ JOINT SWELLING
- ☐ LIMITATION OF ACTIVITY
- ☐ MUSCLE PAIN
- ☐ MUSCLE WEAKNESS
- ☐ RECENT FALLS
- ☐ STIFFNESS
- ☐ UNSTEADY GAIT

SKIN/HEMATOLOGIC/LYMPHATIC
- ☐ ANEMIA
- ☐ CUTS SLOW TO HEAL
- ☐ EASY BRUISE OR BLEED
- ☐ RASHES

GASTROINTESTINAL
- ☐ BLOOD IN STOOL
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ NAUSEA/VOMITING

NEUROLOGICAL
- ☐ DIZZINESS
- ☐ BURNING/NUMBNESS/TINGLING
  WHERE: _____
- ☐ TREMORS

CARDIAC
- ☐ CHEST PAIN
- ☐ IRREGULAR HEART BEATS
- ☐ SWELLING OF HANDS OR FEET

GENITOURINARY
- ☐ BLOOD IN URINE
- ☐ BURNING/PAINFUL URINATION
- ☐ INCONTINENCE

LIST ALL KNOWN ALLERGIES TO MEDICATIONS ☐ NO MEDICATION ALLERGIES

1. _____ REACTION TYPE:_____
2. _____ REACTION TYPE:_____
3. _____ REACTION TYPE:_____

☐ Latex Allergy ☐ PCN ☐ Adhesive Allergy ☐ Poultry /Egg Allergy Other Allergies: _____

HISTORY AND PHYSICAL

CURRENT MEDICATIONS ☐ **NO CURRENT MEDICATIONS**

DRUG NAME	STRENGTH	DOSE	FREQUENCY	PRESCRIBING MD

PAST SURGICAL HISTORY ☐ **NO SURGICAL HISTORY**

- ☐ ADENOIDECTOMY
- ☐ APPENDECTOMY
- ☐ COLON SURGERY
- ☐ BREAST SURGERY
- ☐ HEART BYPASS/CABG
- ☐ CAROTID SURGERY
- ☐ CATARACT SURGERY
- ☐ CESAREAN SECTION (C-Section)
- ☐ GALLBLADDER REMOVAL
- ☐ HEART ANGIOPLASTY
- ☐ HERNIA REPAIR
- ☐ HYSTERECTOMY
- ☐ STENT
- ☐ PACEMAKER
- ☐ SINUS SURGERY
- ☐ TONSILLECTOMY
- ☐ TURP (PROSTATE)
- ☐ IMPLANTABLE PUMPS/OTHER IMPLANT

PAST ORTHOPAEDIC HISTORY ☐ **NO ORTHOPAEDIC HISTORY**

- ☐ ACL RECONSTRUCTION R L
- ☐ AMPUTATION
- ☐ ARTHROSCOPY
  - ☐ HIP: R L
  - ☐ KNEE: R L
  - ☐ SHOULDER: R L
- ☐ BUNIONECTOMY R L
- ☐ CARPAL TUNNEL SYNDROME R L
- ☐ CERVICAL SPINE (NECK) SURGERY
- ☐ FUSION (SPINAL)
- ☐ FASCITIS
- ☐ FASCIECTOMY
- ☐ FRACTURE
- ☐ INJECTIONS
  - ☐ HIP: R L
  - ☐ KNEE: R L
  - ☐ SHOULDER: R L
  - ☐ ELBOW: R L
  - ☐ WRIST: R L
  - ☐ HAND: R L
  - ☐ ANKLE: R L
  - ☐ FOOT: R L
  - ☐ SPINE: R L
- ☐ JOINT FUSION
- ☐ LUMBAR SPINE SURGERY
- ☐ NERVE REPAIR
- ☐ PATELLA DISLOCATION
- ☐ ROTATOR CUFF REPAIR
- ☐ SPINAL STIMULATOR
- ☐ TENDON/LIGAMENT TEARS
- ☐ THORACIC SPINE SURGERY
- ☐ TOTAL HIP REPLACEMENT R L
- ☐ TOTAL KNEE REPLACEMENT R L
  - ☐ UNICOMPARTMENT R L
  - ☐ PATELLOFEMORAL JOINT R L
- ☐ TOTAL SHOULDER REPLACEMENT R L
- ☐ TRIGGER FINGER RELEASE
- ☐ ULNAR NERVE DECOMPRESSION

ANESTHESIA: Any adverse reactions? ☐ Y ☐ N Describe reaction _____

_____

SOCIAL HISTORY

TOBACCO USE: ☐ CURRENT PACKS/DAY: _____ ☐ FORMER ☐ NEVER ☐ CHEWING TOBACCO ☐ VAPE

ALCOHOL USE: ☐ YES ☐ NO IF YES, HOW MUCH PER DAY _____ WHAT TYPE: _____

RECREATIONAL DRUGS: ☐ YES ☐ NO IF YES, WHICH DRUGS: _____

HOBBIES, SPORTS, OR EXERCISE: _____

FAMILY HISTORY ☐ **NO FAMILY HISTORY**

- ☐ ADOPTED: HISTORY UNKNOWN
- ☐ ANEMIA
- ☐ BLEEDING DISORDERS/CLOTTING
- ☐ HIGH CHOLESTEROL
- ☐ STROKE
- ☐ DVT/BLOOD CLOTS/ PULMONARY EMBOLISM
- ☐ OSTEOPOROSIS
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ CANCER TYPE(S) _____
- ☐ OSTEOARTHRITIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ LUPUS

EMOTIONAL/SPIRITUAL/CULTURAL HISTORY

MENTAL/EMOTIONAL: ☐ ANXIETY ☐ DEPRESSION ☐ RECENT JOB LOSS ☐ DEATH OF SOMEONE CLOSE TO YOU

☐ CURRENTLY UNDER THE CARE OF A PSYCHIATRIST/PSYCHOLOGIST NAME: _____

DO YOU LIVE ALONE? ☐ YES ☐ NO

DO YOU HAVE CONCERNS ABOUT YOUR SAFETY, SAFETY OF ANYONE IN YOUR HOME OR THE SECURITY OF YOUR PROPERTY: ☐ YES ☐ NO

_____ _____

SIGNATURE OF PATIENT **DATE/TIME** **SIGNATURE OF PHYSICIAN** **DATE/TIME**

HISTORY AND PHYSICAL