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Orthopedic and Health Assessment

Please complete this detailed form to assist your Doctor. The details of your medical history will be helpful in arriving at a more precise diagnosis, to suggest appropriate testing and to evaluate your possible medical risks if surgery is needed. Please ask for assistance if you need help in completing this form. Thank you for your time.

Name _____ Age _____ Height _____ Weight _____

Today's Date _____ Birthdate _____

Occupation _____ Job Duties _____

Primary Care Physician _____ Primary Language Spoken _____

Reason for Today's Visit _____

_____ Right Left Both

Please describe your current symptoms, orthopedic problem(s) or concerns _____

Is your problem due to an accident? Yes No If yes, where did the accident occur? _____

Have you missed work or school because of your injury? Yes No

Last day worked? _____ Were you seen in an ER for this injury? Yes No

List any treatments or medications you have tried for the above problem(s) _____

Have you had x-rays, MRI, or other tests? Yes No

If yes, where? Dates? _____

List any medical problems that you have been treated for in the past or being treated for in the present _____

List all current and/or previous treating physicians _____

List any previous surgeries and dates (all types) _____

Specific concerns or questions you would like to address? _____

Name: _____

Please provide a list from home or write below all medications with dosages and intervals(once a day, twice a day, etc.). Please include prescription, over the counter, vitamins and alternative medications.

_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: Are you allergic or react adversely to any of the below?

Latex	Yes	No	Reaction: _____
Penicillin	Yes	No	Reaction: _____
Sulfa Drugs	Yes	No	Reaction: _____
Adhesive Tape	Yes	No	Reaction: _____
Aspirin/NSAIDs	Yes	No	Reaction: _____
Eggs/Feathers	Yes	No	Reaction: _____
Flu Shots	Yes	No	Reaction: _____
Novacaine	Yes	No	Reaction: _____
Cortisone	Yes	No	Reaction: _____
Tetracycline	Yes	No	Reaction: _____
Iodine Dye	Yes	No	Reaction: _____
Other (s)	_____		

Do you get nauseated, vomit or other adverse reactions with narcotic pain meds, surgery or anesthesia?

Yes No Type _____

PATIENT MEDICAL HISTORY

Please circle yes or no, and list type of problems. PLEASE, do NOT leave any blank.

Current Infection	Yes	No	Where & When _____
Recent Weight Change	Yes	No	Loss/Gain (circle) Amount _____ lbs
Problem Headaches	Yes	No	Migraines/Other (circle) _____
Seizures (ever)	Yes	No	When & Cause _____
Dementia/Memory Loss	Yes	No	Cause _____ Age _____ Alzheimer's _____ MiniStrokes
Phlebitis/DVT (ever)	Yes	No	Year _____
Cancer	Yes	No	Type _____ Year _____

NAME: _____

Asthma	Yes	No	Current OR Past
Sleep Apnea	Yes	No	Do you use CPAP at bedtime? Yes No
Previous Pneumonia	Yes	No	When? _____
Arthritis	Yes	No	Type _____
Stroke/TIA	Yes	No	Year _____ Symptoms _____
Hypertension	Yes	No	Year Diagnosed _____
Pacemaker	Yes	No	Year _____ Dr./Hospital _____
Cardiac Stent(s)	Yes	No	Year(s) _____ Dr./Hospital _____
Diabetes	Yes	No	Year Diagnosed _____
Recent Appetite Changes	Yes	No	Increased Decreased
GERD/Reflux	Yes	No	Treated? Yes No
GI Ulcer (ever)	Yes	No	Year _____ Esophagus Gastric Duodenal
GI Bleeding (ever)	Yes	No	Upper Lower Unknown
Urinary Tract Infection	Yes	No	Last one? _____ Recurrent? _____
Kidney Failure	Yes	No	Nephrologists name _____ Dialysis ___ Yes No
Viral Hepatitis	Yes	No	Type _____ Active Yes No
Blood Clotting Disorder	Yes	No	Factor V (five)Leiden Yes No
Thyroid Disorders	Yes	No	Hypo (low) Hyper (overactive)
Prior Blood Transfusion(s)	Yes	No	If Yes, when _____ Reason _____
Solid Organ Transplant	Yes	No	Type _____ Reason _____ Date _____
Hard of Hearing	Yes	No	If yes, Hearing Aids Yes No
Rash/Skin Conditions	Yes	No	Acne ___ Eczema ___ Psoriasis ___ Other ___

Recent Fever	Yes	No	Recent Dizziness	Yes	No
Parkinson's Disease	Yes	No	Paralysis	Yes	No
Multiple Sclerosis	Yes	No	Neuropathy	Yes	No
Glaucoma	Yes	No	Contacts	Yes	No
Eye Glasses	Yes	No	Home Oxygen	Yes	No
Breathing Problems	Yes	No	Emphysema	Yes	No
Lyme Disease	Yes	No	Rheumatic Fever	Yes	No

NAME: _____

Congestive Heart Failure	Yes	No	Heart Attack/MI	Yes	No
Irregular Heart Beat	Yes	No	Fainting	Yes	No
RSD/Causalgia	Yes	No	Mitral Valve Prolapse	Yes	No
Hardening of Arteries/PVD	Yes	No	Varicose Veins	Yes	No
Abdominal Aneurysm	Yes	No	Blood Clots (ever)	Yes	No
Recent Diarrhea	Yes	No	Recurrent Constipation	Yes	No
Trouble Swallowing (Food/Pills)	Yes	No	Esophagus Stricture	Yes	No
Jaundice	Yes	No	Liver Problems	Yes	No
Cirrhosis	Yes	No	Alcoholism	Yes	No
Gout/High Uric Acid	Yes	No	Prostate Problems	Yes	No
Trouble Voiding	Yes	No	Urinary Incontinence	Yes	No
Kidney Stones	Yes	No	Venereal Disease	Yes	No
Gall Bladder Problems	Yes	No	Slow Healer	Yes	No
Excess Bleeding Disorder	Yes	No	Anemia (blood disorder)	Yes	No
Anxiety Disorder	Yes	No	ADHD	Yes	No
Bipolar Disorder	Yes	No	Schizophrenia	Yes	No
Learning Disability	Yes	No	Depression	Yes	No
Polio	Yes	No	Cerebral Palsy	Yes	No
Back Problems	Yes	No	Knee Problems	Yes	No
Unsteady Walk/Falls	Yes	No	Shoulder Problems	Yes	No
Carpal Tunnel Syndrome	Yes	No			

SOCIAL HISTORY

How much caffeine do you consume in one day? _____

Do you use tobacco products? Yes No How long have you used? _____

If yes to above, Cigarettes Cigars Chewing Tobacco How much per day? _____

Are you interested in quitting smoking or chewing? Yes No Maybe

Do you drink alcohol containing beverages? Yes No How much per day? _____ Type _____

Social inhaled and/or street intravenous drugs (past or present) Yes No

Type and when _____

Do you have a high stress level? Yes No Do you feel you are handling it well? Yes No

NAME: _____

FAMILY MEDICAL HISTORY

Please list **ANY** and **ALL** known diseases that run in your family including abnormal reactions to surgery, such as prolonged time to wake up from anesthesia or severe fevers (Malignant Hyperthermia). If cancer runs in your family, please list who had it, their age and type of cancer.

Mother's Side (Patient's mother, aunts and uncles) _____

Father's Side (Patient's father, aunts and uncles) _____

Siblings (Patient's brother/sisters) _____

Are your parents still living? Mother Yes No Father Yes No

If not, age and cause of death _____

MEDICATIONS

Circle Yes or No if you are taking any of these medications or over-the-counter products.

Blood Thinners

Aspirin (ASA) 81 mg or 325 mg	Yes	No	Plavix (Clopridgel)	Yes	No
Persantine	Yes	No	Aggrenox	Yes	No
Warfarin/Coumadin	Yes	No	Lovenox	Yes	No

Reason for taking _____

OTC Non-Steroidal Anti-Inflammatory Medication

Advil (Ibuprofen)	Yes	No	Aleve(Naproxen)	Yes	No
Dristan Sinus Tablets	Yes	No	Midol	Yes	No
Motrin	Yes	No	Naprosyn	Yes	No

Complimentary/Alternative Medicines

Chondroitin	Yes	No	Garlic	Yes	No
Ginkgo	Yes	No	Vitamin E	Yes	No