Ortho Nebraska Clinics

Date: _____

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Referred By: (First) _____ (Last) _____

Primary Physician: (First) _____ (Last) _____

Pharmacy: _____

Pharmacy Phone Number: _____

Chief Complaint

☐Right ☐Left ☐Bilateral Body Part _____

History of present illness (Answer these questions regarding your current problem(s) only.)

What symptoms are you experiencing? How did it happen? _____

_____

Pain Description: ☐Throbbing ☐Burning ☐Sharp ☐Numbness ☐Dull/Aching ☐Shooting ☐Pressure ☐Tingling

On a scale of 0-10, how severe is your pain? (1 = no pain present, 10 = worst pain of your life) _____

Do any of the following activities make it worse? (Check all that apply)

☐ Standing ☐ Exercise ☐ Lying Down ☐ Rising from a Chair ☐ Other: _____

☐ Sitting ☐ Lifting ☐ Walking ☐ Activities of Daily Living _____

Do any of the following make it better? ☐ Medication ☐ Relaxation/Rest ☐ Other: _____

How long have you had this problem? What is the date of injury? _____

Is this a sports related injury? ☐Yes ☐No If yes, name the school/club: _____

Check any previous treatment(s) you've had for this problem, if applicable:

☐ Emergency Room ☐ Physical Therapy ☐ Chiropractor ☐ Anti-Inflammatories/NSAIDs

☐ Bracing ☐ Injection ☐ Surgery ☐ Other: _____

Have you had any of the following diagnostic studies for your current problem?

☐ X-Rays	Where: _____	When: _____
☐ CT	Where: _____	When: _____
☐ MRI	Where: _____	When: _____
☐ Myelogram	Where: _____	When: _____
☐ Epidural steroid/injection	Where: _____	When: _____
☐ EMG/NCV	Where: _____	When: _____

Work/Auto Related (Only if Applicable)

Is this a Workers' Compensation case?	☐Yes	☐No	Date of Injury: _____
Is this a result of an auto accident?	☐Yes	☐No	Date of Injury: _____
Do you have an attorney assisting you?	☐Yes	☐No	
Is there any legal action pending?	☐Yes	☐No	

Medications **Please list all current medications and dosages, or bring current list to your scheduled appointment.**

☐ I am currently not taking any medications prescribed or over-the-counter.

_____ _____

_____ _____

_____ _____

If you are over the age of 65, have you had a pneumonia immunization? ☐Yes ☐No

Did you receive an influenza immunization this season? (October 1 - March 31) ☐Yes ☐No

Allergies to Medications, X-Ray Dye, Metals and/or Soaps

☐No Known Allergies ☐ Yes (please list and indicate reaction): _____

Social History

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated

Employer: _____ ☐Retired ☐Disabled ☐Unemployed

What kind of work do you do? _____

Are you a student? ☐Yes ☐No If yes, please list your grade and school name: _____

Do you exercise regularly? ☐Yes ☐No

Do you use any of the following? (check all that apply)

☐Alcohol (Number of Drinks per day: _____) ☐E-cigarettes or vapor cigarettes

☐Cigarettes/Tobacco (Previous use? _____ Date Quit: _____) ☐Non-prescription, mind-enhancing drugs

☐Performance Enhancing Drugs (Please list: _____)

Past Medical History (Check all that apply)

☐Heart Disease	☐Stroke	☐Liver Disease	☐Multiple Sclerosis
☐Lung Disease	☐Dementia	☐Fibromyalgia	☐Claustrophobia
☐Asthma	☐High Blood Pressure	☐Gout	☐Hepatitis A/B/C (circle one)
☐Diabetes	☐Cancer	☐Skin Infection/MRSA	☐HIV
☐Gastric Ulcer	☐Kidney Disease	☐Cellulitis	☐Reaction to Anesthesia
☐Anxiety	☐Blood Disorder	☐Sleep Apnea/C-PAP	☐Other _____
☐Depression	☐Thyroid Disorder	☐Blood Clots/DVT	☐Other _____
☐Osteoarthritis	☐Osteoporosis	☐Pulmonary Embolism	☐Other _____

Family History (Please check where applicable)

Heart Disease	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son
High Blood Pressure	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son
Stroke	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son
Diabetes	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son
Cancer	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son
Bleeding/Clotting	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son
Anesthesia Problems	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son
Gout	☐Father	☐Mother	☐Sister	☐Brother	☐Daughter	☐Son

Procedure History (Please list all past procedures)

☐None ☐Orthopaedic: (procedure & date) _____

☐Stent Placement: (date) _____ ☐Heart Bypass: (date) _____

☐Pacemaker ☐Hysterectomy ☐Appendectomy ☐Gall Bladder ☐Sinus

☐C-Section ☐Tubal Ligation ☐Tonsils ☐Tubes (Ear) ☐Vasectomy

☐Other: _____

Review of Systems (Please mark current systems)

Constitutional	Endocrine	Neurologic	HEENT	Gastrointestinal
☐Normal	☐Normal	☐Normal	☐Normal	☐Normal
☐Obesity	☐Excessive Sweating	☐Vertigo/Dizziness	☐Visual Problems	☐Nausea
☐Weight Change	☐Excessive Thirst	☐Motor Disturbances	☐Loss of Hearing	☐Vomiting
☐Fever		☐Numbness	☐Headache	☐Heartburn/Acid Reflux
☐Chills		☐Tingling	☐Tooth Pain	
☐Night Sweats				

Psychiatric	Cardiovascular	Genitourinary	Hematologic	Skin
☐Normal	☐Normal	☐Normal	☐Normal	☐Normal
☐Anxiety	☐Chest Pain	☐Urinary Incontinence	☐Easy Bleeding	☐Rashes
☐Depression	☐Difficulty Breathing	☐Urinary Frequency	☐Easy Bruising	☐Skin Lesions

Musculoskeletal	Respiratory	Allergies
☐Normal	☐Normal	☐Normal
☐Other Joint Pain	☐Shortness of Breath	☐Swollen glands in Neck
		☐Seasonal Allergies

Patient/Guardian Signature: _____ **Date:** _____

Reviewed by: _____