AZALEA ORTHOPEDICS

PATIENT MEDICAL PROFILE

Visit Information

Patient Name: ____ DOB: __________ Age: _______

Reason for Visit: ______________________________________ Referring Physician: ____________

Primary Care Physician: _________________________________ Height: _________ Weight: _____

Type of Pain: ☐Ache ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click / Pop Date of Injury: ___/___/___

Severity: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable Are you left of right handed? ☐ Left ☐ Right ☐ Both

Location of Pain: Back _________% Legs _________% OR Neck _________% Arms _________%

Duration of Pain: _______ ☐ Dull then Sharp ☐ Always There ☐ Very Sharp, the Leaves ☐ Constant ☐ Intermittent

Pain Aggravated By:

- ☐ Standing
- ☐ Walking
- ☐ Stairs
- ☐ Driving
- ☐ Working
- ☐ Sleeping
- ☐ Lying
- ☐ Sitting

Treatments Attempted:

- ☐ Pain Medications (how long _______)
- ☐ Anti-Inflammatory (how long ____)
- ☐ Rest
- ☐ Wheelchair
- ☐ Physical Therapy (how long _______)
- ☐ Surgery
- ☐ Ice
- ☐ NONE
- ☐ Oral Steroids (how long _______)
- ☐ Epidural Steroid Injections

History of Present Illness

Was this a work related accident? Yes No

Was this an auto accident? Yes No

Recreational or school athletic injury? Yes No

Accident in your home? Yes No

Accident other than above? Yes No

Explain: ______________________________

Are you currently working? Yes No

If yes, are you working: Full Duty or Limited Duty

List any other doctors you have seen for this problem:

____

____

List any previous tests or procedures for this problem:

____

____

Explain Injury or Illness:

____

____

____

Describe the symptoms you are having:

____

____

____

Does the problem interfere with your normal functions?

Yes No If yes, explain: __________________

____

Do you have a history of MRSA?

Yes No If yes, explain: __________________

____

Current Health

Please list any health problems that you are currently diagnosed with:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ DVT (Blood Clots)
- ☐ Pulmonary Embolism
- ☐ Liver Disease / Jaundice
- ☐ Lung Disease
- ☐ Cancer
- ☐ Stomach Ulcers
- ☐ Seizures
- ☐ Osteoarthritis / Gout
- ☐ Asthma
- ☐ Thyroid Problems
- ☐ Kidney Disease
- ☐ Rheumatoid Arthritis
- ☐ Chronic Headache
- ☐ Depression
- ☐ Anxiety
- ☐ Urinary or Bowel Incontinence
- ☐ Infections: Please Explain: ____
- ☐ Other Illness: Please Explain: ____

Females Only: Date of Last Menstrual Period: ___/___/___ Currently Pregnant? ☐ Yes ☐ No ☐ Possibly

Check Immunizations: ☐ Flu – Approx. Date: __/__/__ ☐ Tetanus – Approx. Date: __/__/__ ☐ Pneumonia – Approx. Date: __/__/__

☐ Colon Screening – Approx. Date: __/__/__ ☐ Mammogram – Approx. Date: __/__/__ ☐ Bone Density – Approx. Date: __/__/__

Allergies

Please check all known Drug Allergies:

- ☐ None known
- ☐ Iodine
- ☐ Diagnostic Dyes
- ☐ Morphine
- ☐ Penicillin
- ☐ Codeine
- ☐ Aspirin
- ☐ Tramadol
- ☐ Sulfa Drugs
- ☐ Hydrocodone
- ☐ Latex
- ☐ Cephalosporins
- ☐ Other:____

Surgical History

Please list any previous surgeries, or spinal injections, and approximate dates of surgery or injections

Surgery Name: Approximate Date:

____ ___/___/___
____ ___/___/___
____ ___/___/___
____ ___/___/___
____ ___/___/___

Known Allergies to Anesthesia: ☐ Yes ☐ No

Medications

Please list any medications that you currently use, including over-the-counter medications, vitamins, herbs, and prescribed drugs.

Medication Name: ☐ NONE Dosage:

____ __________________________________
____ __________________________________
____ __________________________________
____ __________________________________
____ __________________________________
____ __________________________________
____ __________________________________
____ __________________________________
____ __________________________________

Blood Thinners

Please check all Blood Thinners that you are taking:

☐ None Known ☐ Aspirin ☐ Excedrin ☐ Fish Oil / Omega 3 ☐ BC Powder
☐ Pradaxa ☐ Eliquis ☐ Xarelto ☐ Effient ☐ Brilinta
☐ Other:____

Family History

Problem:	Does it run in your family?	Family Member(s) who have had this issue:
Diabetes	☐ Yes ☐ No	________________________________
Heart Disease	☐ Yes ☐ No	________________________________
Asthma	☐ Yes ☐ No	________________________________
Blood Clots	☐ Yes ☐ No	________________________________
Arthritis	☐ Yes ☐ No	________________________________
Hip Problems	☐ Yes ☐ No	________________________________
Cancer	☐ Yes ☐ No	________________________________

Other: ____

Social History

Occupation: Current: _________________________ Past: _________________________
☐ Disabled Reason for Disability: _______________ ☐ Retired: _____________________
Do you live alone? ☐ Yes ☐ No With whom: ____
Do you smoke? ☐ Yes ☐ No ______ packs/day Quit: ______ Months Ago ______ Years Ago
Do you drink alcohol? ☐ Yes ☐ No ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently
Any substance abuse? ☐ Yes ☐ No Please List: ____

Signatures

Patient Signature: ____ Date: ___/___/___
Reviewed by Clinical Staff: _____________________________________ Date: ___/___/___
Reviewed by Pre-Op Staff: ______________________________________ Date: ___/___/___