Northside Cherokee
ORTHOPEDICS & SPORTS MEDICINE

Name: ______________________ DOB: __________ Height: __________ Weight: ______________

Referred by: ______________________ Primary Care Physician: ______________________

Have you seen another physician regarding this condition? Yes / No If yes, list names and dates: ______________________

____

PAST MEDICAL HISTORY

• **Neurological**

Stroke	YES	NO
Concussion	YES	NO
Peripheral Neuropathy	YES	NO
Epilepsy/Seizures	YES	NO

• **Cardiovascular**

Heart Attack	YES	NO
High Blood Pressure	YES	NO
Coronary Artery Disease	YES	NO
Elevated Cholesterol	YES	NO
A-Fib/Irregular Heartbeat	YES	NO
Pacemaker	YES	NO

• **Kidney**

Renal Insufficiency	YES	NO
Kidney Stones	YES	NO
One Kidney/Abnormal Kidney	YES	NO

• **Gastrointestinal**

Ulcers	YES	NO
Reflux	YES	NO
Intolerance to NSAIDS	YES	NO

• **Skin**

Psoriasis	YES	NO
History of skin rash	YES	NO

• **Endocrine**

Diabetes	YES	NO
Thyroid Disease	YES	NO
Prednisone Use	YES	NO

• **Pulmonary**

Asthma	YES	NO
Emphysema	YES	NO
COPD	YES	NO
Pulmonary Embolism	YES	NO

• **Infectious**

HIV/AIDS	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
TB	YES	NO
Recent Tick Bite	YES	NO
MRSA	YES	NO

• **Cancer**

Type:	YES	NO

• **Musculoskeletal**

Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Fibromyalgia	YES	NO
Osteoporosis	YES	NO
Gout	YES	NO

• **Hematological**

Bleeding Problems	YES	NO
Blood Clots	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO

If you answered yes to any question, please explain:

Problem Not Listed

Explain:	YES	NO

REVIEW OF SYSTEMS
Are you experiencing any of the following?

• **Neurological**

Dizziness	YES	NO
Vertigo	YES	NO
Fainting	YES	NO
Motor disturbances	YES	NO
Sensory disturbance	YES	NO

• **Cardiovascular**

Chest pain or discomfort	YES	NO
Fast heart rate	YES	NO
Palpitations	YES	NO

• **Otolaryngeal**

Earache	YES	NO
Hearing loss	YES	NO
Ringing in Ears	YES	NO
Nosebleeds	YES	NO
Nasal discharge	YES	NO
Mouth Sores	YES	NO
Bleeding gums	YES	NO
Hoarseness	YES	NO
Throat Pain	YES	NO

• **Pulmonary**

Coughing up blood	YES	NO
Cough	YES	NO
Wheezing	YES	NO
Difficulty breathing	YES	NO

• **Constitutional**

Recent change in weight	YES	NO
Chills	YES	NO
Fever	YES	NO
Sweating heavily at night	YES	NO

• **Gastrointestinal**

Difficulty swallowing	YES	NO
Heartburn	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Abdominal pain	YES	NO
Diarrhea	YES	NO
Black or tarry stool	YES	NO

• **Hematologic**

Easy bleeding	YES	NO
Easy bruising	YES	NO

• **Genitourinary**

Blood in Urine	YES	NO
Bowel/bladder changes	YES	NO
Bladder pain	YES	NO

• **Musculoskeletal**

Joint stiffness	YES	NO
Muscle aches	YES	NO
Joint pain	YES	NO

• **Skin**

Itching	YES	NO
Skin lesion	YES	NO
Skin rash	YES	NO

• **Claustrophobic**

	YES	NO

HISTORY AND PHYSICAL

ALLERGIES:

☐ I have no allergies to medications ☐ I have no allergies to foods Allergic to metal ☐ Yes ☐ No

Allergic to:	Reactions:

CURRENT MEDICATIONS: (include dosage) If dosage is missing, patient advised to bring in an updated medication list.

PAST SURGICAL PROCEDURES: (please list all and year)

FAMILY HISTORY: (parents, siblings and grandparents)

☐ Unknown family medical history

☐ Diabetes ☐ Heart Disease ☐ Bleeding problems ☐ Lung disease

☐ Blood clots ☐ Stroke ☐ Cancer ☐ Kidney disease

☐ Hip/spine fracture ☐ High Blood Pressure ☐ Osteoporosis ☐ Sickle Cell Anemia

SOCIAL HISTORY:

What is your current occupation ______________________________

Are you currently pregnant or nursing? ☐ Yes ☐ No

Do you currently use tobacco products? ☐ Yes ______ ppd ☐ No

Quit smoking? ☐ Yes ☐ No

Do you drink alcohol? ☐ Never ☐ Daily ☐ 1-2 week ☐ 1-2 month ☐ 1-2 year

Do you currently use or have a history of illicit substance abuse? ☐ Yes ☐ No

EMOTIONAL/SPIRITUAL/CULTURAL NEEDS:

Mental/Emotional: ☐ Anxiety ☐ Depression ☐ Job Loss ☐ Divorce ☐ Death of Someone Close to you ☐ New Job

☐ Under Care of Psychiatrist/Psychologist Name: ______________________ Live alone? Y / N

Do you have concerns about your safety, the safety of anyone in your home or security of your property? Y / N

Patient signature:______________________ Date/Time: ______________________

Physician's signature: ______________________ Date/Time: ______________________