

# KLAMATH ORTHOPEDIC AND SPORTS MEDICINE CLINIC

## HISTORY OF CURRENT CONDITION

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for being seen today: \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

Is this the result of an injury or accident? \_\_\_\_\_

If accident, what is the date of injury? Briefly describe the accident \_\_\_\_\_

Have you received prior treatment for this issue/injury? \_\_\_\_\_

Have you had any of the following studies performed on the affected body part in the past six months?

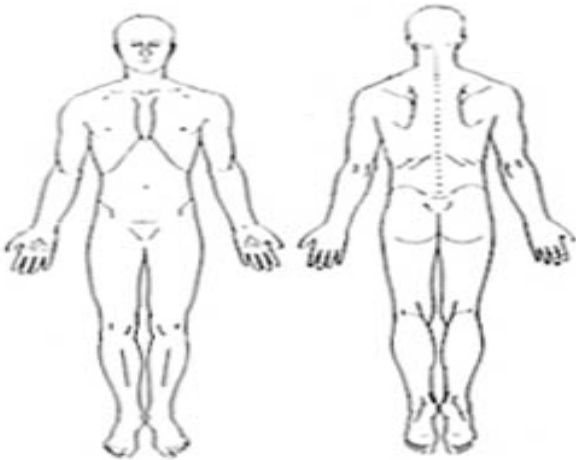
XRAY                      Yes / No      If yes, when/where was XRAY performed: \_\_\_\_\_

MRI                        Yes / No      If yes, when/where was MRI performed: \_\_\_\_\_

Nerve Conduction      Yes / No      If yes, when where was NCS performed: \_\_\_\_\_

Have you had a similar problem before? When? \_\_\_\_\_

What relieves the symptoms? \_\_\_\_\_



If you have pain, please describe it and rate it on a scale from 0 – 10, with 0 meaning “no pain” and 10 meaning “worst ever”: \_\_\_\_\_

Does the pain radiate anywhere? From where to where (example: down arm; down leg) \_\_\_\_\_

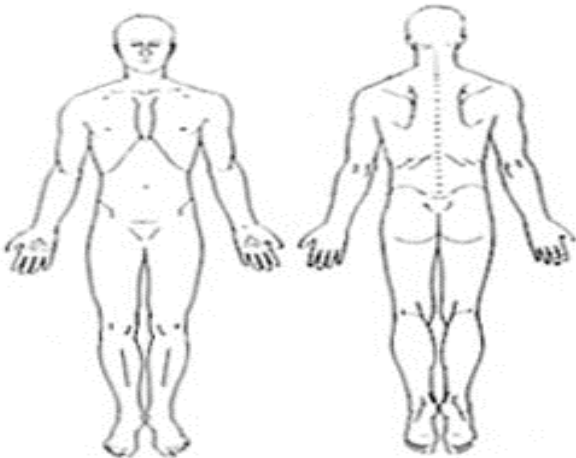
Using the diagram, please indicate where your pain is located.

Do you have any new health conditions since you were last seen? \_\_\_\_\_

\_\_\_\_\_

Treatments? \_\_\_\_\_

\_\_\_\_\_



## KLAMATH ORTHOPEDIC AND SPORTS MEDICINE CLINIC MEDICAL HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_ Family Physician: \_\_\_\_\_

**Dominant Hand: Left / Right    Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F    BMI: \_\_\_\_\_**

Review of symptoms (HAVE YOU HAD, OR DO YOU PRESENTLY HAVE):

	YES	NO		YES	NO
Seizure			Osteoporosis		
Stroke			Depression		
Angina (Chest Pain)			Anxiety		
Other Heart Problems/HBP			Psychiatric problems		
Asthma			Do you have a psychiatrist?		
Sleep Apnea			Change in bowel habits		
Bronchitis			Anemia		
Hearing loss			Chemical dependency		
Visual loss or glaucoma			Alcoholism		
Night Sweats			Bleeding problems		
Weight gain			Difficulty voiding		
Weight loss			Kidney or bladder infections		
Cancer			Psoriasis or other skin problems		
Diabetes			Have you used steroids?		
Hepatitis or jaundice			Do you smoke?		
HIV			If so, how many packs per day? _____		
Ulcer/GERD/Indigestion			Do you know about the risks of smoking?		
Thyroid problems			Do you have a primary care physician?		
Blood Clots			Reaction to general anesthetic or local anesthetic?		

Other Medical Problems not listed above (please include what, when and how):

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

(Please add to reverse side if there are additional medical problems)

**If you answered yes to any of the above, will you take it upon yourself to seek out a primary care doctor?**

**Yes / No**

Current Medications (please list name, dosage and frequency):

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

(Please add to reverse side if there are additional medications)

Past Surgeries/Broken Bones (Fractures) / Please include year with description:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

(Please add to reverse side if there are additional past surgeries)

**Additional Medical Problems:** \_\_\_\_\_

---

---

---

---

---

---

---

---

**Additional Current Medications:** \_\_\_\_\_

---

---

---

---

---

---

---

---

**Additional Past Surgeries:** \_\_\_\_\_

---

---

---

---

---

---

---

---

**KLAMATH ORTHOPEDIC AND SPORTS MEDICINE CLINIC  
MEDICAL HISTORY**

*Continued*

Name: \_\_\_\_\_

Are you allergic to any of the following [please circle]:

Iodine, Shellfish, Tape, Eggs, Chicken

What type of reaction do you have: \_\_\_\_\_

Are you allergic to latex: Y / N

What type of reaction do you have: \_\_\_\_\_

Any other allergies not listed above. Please include what type of reaction you have:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any stomach or kidney problems or other problems with any of the following [please circle]:

Aspirin, Tylenol, Ibuprofen (Motrin, Nuprin, etc); Naproxen (Naprosyn, Aleve, Anaprox)

Other Anti-inflammatories: \_\_\_\_\_

FAMILY medical history, including who (mother, father, brother, sister):

- Diabetes \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Stroke \_\_\_\_\_
- Osteoporosis \_\_\_\_\_
- Osteoarthritis \_\_\_\_\_
- Rheumatoid \_\_\_\_\_
- Other \_\_\_\_\_

---

---

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

---

---

Additional Physician Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

