



UMC

UNIVERSITY MEDICAL CENTER
707 N. Alvernon, Suite 205
Tucson, AZ 85711



2 2 3 4

MEDICAL RECORD#

DOB

NAME

VISIT#

NEW PATIENT HEALTH HISTORY ORTHOPAEDIC SURGERY

Name: _____ Phone: _____

Address: _____

Height: _____ Weight: _____ Occupation: _____

Referring Physician: _____ Primary Physician: _____

Reason for today's visit: _____

Date of injury: _____ Nature of injury: Sports Work's Comp MVA Other

If sports, name of team/school: _____ If MVA, state where accident occurred: _____

If other, please explain: _____

Check appropriate response:

Dominant Hand (Are you left or right handed?): Right Left

R or L Knee		
Is the injury:	New	Old
Do you have:	Swelling	Giving Way
Can you bear weight?	Yes	No

R or L SHOULDER		
Is the injury:	New	Old
Do you have:	Numbness	Tingling
	Weakness	Pain when throwing

R or L FOOT / ANKLE		
Do you have:	Pain	Swelling
Can you bear weight?	Yes	No

R or L HIP / THIGH / LOWER LEG		
Do you have:	Pain / Burning down leg	Weakness
	Pain / Burning down leg	

R or L ARM / ELBOW / HAND / WRIST			
Do you have:	Numbness	Tingling	Swelling
	Weakness	Stiffness	Pain

BACK				
Do you have	Back			Neck
pain in your:	Upper	Mid	Lower	

Have you had: MRI _____ CT _____ Myelogram _____ X-Ray _____ EMG _____

When: _____

Where: _____

List Current Medications: _____

Allergies: None, or List (include medication, food, environmental): _____

(Continued on other side)



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Do you now or have you ever had the following?

- | | | | |
|------------------------------|--|--|--|
| Heart trouble / chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anticoagulant therapy (blood thinners) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal electrocardiogram | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood vessel disease (phlebitis) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood disease (i.e., anemia) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal chest X-ray | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice, hepatitis, mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal bleeding tendencies | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Positive HIV Test | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal anesthetic reaction | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Pediatric patients only:

Birth history: Full Term Premie (how many weeks?) _____

Birthweight: _____ Birth position: Head first Breech

Age when sat up: _____ Age when walked: _____ Age of 1st menstruation: _____

Does anyone else in family have the same problem as your child? If so, who? _____

Past medical history: _____

Past surgical history: _____

Are you pregnant? Yes No

Do you smoke? Yes No Packs per day? _____ How many years? _____

How often do you drink alcoholic beverages? Never Occasionally Regularly

Medical problems in your immediate family (parents, grandparents, siblings):

Heart disease Cancer Diabetes High blood pressure

Describe your current symptoms and date of onset: _____

Severity of Symptoms:

- Mild - Discomforting - Distressing - Horrible - Excruciating

Patient / Parent / Guardian Signature

Date