COLUMBIA ORTHOPAEDIC GROUP

Patient Name:
Date of Birth:

Encounter Date:

Cog Number :
(Office Use Only)

NEW PATIENT HISTORY FORM

Patient Information

Vital Signs: Height: Weight:

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other

Preferred Language ☐ English ☐ Spanish ☐ Chinese ☐ Other

Preferred Pharmacy

Referral Source:

Referring Physician:

Primary Care Physician:

Other: (ex. Google Search, Friend, Other Patient)

Chief Complaint

Dominant hand:

☐ Right hand ☐ Left Hand ☐ Ambidextrous

Description of the symptoms (select only one)

☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness Other:

Shoulder	☐ Right	☐ Left	☐ Both
Upper Arm	☐ Right	☐ Left	☐ Both
Elbow	☐ Right	☐ Left	☐ Both
Forearm	☐ Right	☐ Left	☐ Both
Wrist	☐ Right	☐ Left	☐ Both
Hand	☐ Right	☐ Left	☐ Both
Thumb	☐ Right	☐ Left	☐ Both
Index	☐ Right	☐ Left	☐ Both
Middle	☐ Right	☐ Left	☐ Both
Ring	☐ Right	☐ Left	☐ Both
Small	☐ Right	☐ Left	☐ Both

Pelvis	☐ Right	☐ Left	☐ Both
Hip	☐ Right	☐ Left	☐ Both
Thigh	☐ Right	☐ Left	☐ Both

Neck	☐
Upper Back	☐
Mid Back	☐
Low Back	☐
Buttocks	☐
Tail Bone	☐

Knee	☐ Right	☐ Left	☐ Both
Lower Leg	☐ Right	☐ Left	☐ Both
Ankle	☐ Right	☐ Left	☐ Both
Foot	☐ Right	☐ Left	☐ Both
Great Toe	☐ Right	☐ Left	☐ Both
2nd Digit	☐ Right	☐ Left	☐ Both
3rd Digit	☐ Right	☐ Left	☐ Both
4th Digit	☐ Right	☐ Left	☐ Both
5th Digit	☐ Right	☐ Left	☐ Both

History of Present Illness

1. Is your problem the result of an injury or accident?

☐ No injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury

2. Have you had a problem like this before? ☐ Yes ☐ No

3. Have you been seen in ER for current complaint? ☐ Yes ☐ No

4. Rate your level of pain today (10 being the most pain).

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. Do the symptoms wake you from your sleep? ☐ Yes ☐ No

6. Please describe the symptoms.

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing
☐ Aching ☐ Burning ☐ Shooting

7. What is the timing of the symptoms?

☐ Constant ☐ Intermittent (comes & goes)

8. Is the problem getting better or worse?

☐ Getting better ☐ Getting worse ☐ Unchanged

9. What makes the symptoms worse?

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending

☐ Stairs ☐ Twisting ☐ Moving ☐ Running
☐ Standing ☐ Walking ☐ Athletics ☐ Lying in Bed
☐ Gripping ☐ Lifting ☐ Reaching Overhead

10. Are there any other symptoms associated to this problem:

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness
☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking
☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way

Staff ONLY enter History (Please type full sentences)

☐ Patient has Radiologic Images at , and
☐ Images WERE loaded into Viztek PACS
☐ Images WERE NOT loaded into Viztek PACS

Prior Treatment / Testing

Have you had any prior tests for your current problem?

☐ None ☐ X-rays ☐ Labs ☐ MRI ☐ Dexa Scan
☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG) ☐ CT/Myelo

Did you have any prior treatments for this problem? ☐ Yes ☐ No

Type of treatment:	Status of symptoms after treatment (Select only those that apply):	Date treatment was received:
Ice	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Heat	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Rest	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
NSAIDs (Aleve, Ibuprofen)	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Muscle Relaxers	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Pain Medications	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Chiropractor	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Physical Therapy	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Home Exercise Program	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Surgery	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Injections	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Bracing	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	
Tens Unit	☐ Temporarily Improved ☐ Worsened ☐ Unchanged	

Patient Name:
DOB:

Other/Comments:

Past Surgical History

Select all previous hospitalizations/surgeries: ☐ **None**

	Year	**Orthopedic Surgery:**	Year
☐ Aneurysm (Brain) Surgery		☐ Arthroscopy Knee - Right	
☐ Aortic Bypass / Vascular Surgery		☐ Arthroscopy Knee - Left	
☐ Appendectomy		☐ Arthroscopy Shoulder - Right	
☐ Cataract (Eye) Surgery		☐ Arthroscopy Shoulder - Left	
☐ Cholecystectomy (Gallbladder)		☐ Carpal Tunnel Release - Right	
☐ Heart Surgery		☐ Carpal Tunnel Release - Left	
☐ Hernia Repair		☐ Rotator Cuff Repair - Right	
☐ Hysterectomy		☐ Rotator Cuff Repair - Left	
☐ LAP Band / Gastric Bypass Surgery		☐ Total Hip Replacement - Right	
☐ Lumpectomy		☐ Total Hip Replacement - Left	
☐ Mastectomy		☐ Total Knee Replacement - Right	
☐ Malignancy / Cancer		☐ Total Knee Replacement - Left	
☐ Stents		☐ Total Shoulder Replacement - Right	
☐ Tonsillectomy		☐ Total Shoulder Replacement - Left	
☐ C-Section		☐ Spinal Surgery - Indicate Level:	
Other Surgery:		Other Orthopedic Surgery:	

Medical Questions

☐ Metal in body ☐ Claustrophobic ☐ Pregnant

☐ Sleep Apnea ☐ Use a C PAP ☐ Snores

Is the patient taking blood thinners? ☐ Yes ☐ No

Have you ever had a blood clot? ☐ Yes ☐ No

If yes, please explain: (Ex: left leg 2015)

Review of Systems

Please indicate if you experience any of the following symptoms in the last 6 months? ☐ NO TO ALL

				Comments
				NONE
1) GI	☐ Heartburn	☐ Nausea, Vomiting	☐ Blood in Stool	☐
2) ENDO	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats	☐
3) CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐
4) EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐
5) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐
	☐ Headache			

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6) CARDIO	☐ Chest Pain	☐ Palpitations		☐
7) LUNGS	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐
8) GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐
9) SKIN	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps	☐
	☐ Psoriasis	☐ Wounds Slow to Heal		
10) NEURO	☐ Frequent Falls	☐ Loss of Coordination	☐ Gait Abnormality	☐
	☐ Change in bowel	☐ Change in bladder	☐ Dizziness	
11) PSYCH	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder	☐
12) HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐

FAMILY HISTORY

Have any direct relatives had any of the following disorders? ☐ NO TO ALL

Father:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	☐ Other:			
Mother:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	☐ Other:			
Sibling:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	☐ Other:			

SOCIAL HISTORY

1. Do you use Tobacco? ☐ Daily ☐ Occasionally ☐ Former ☐ Never ☐ Unknown

Details:

2. Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

3. Marital History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Legally Separated

4. Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled

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Occupation: **Employer:** ☐ **Student**

Enter all information into the Medical Information Tab

Allergy List from Web Portal: ☐ NONE

Medication list from Web Portal: ☐ NONE

Medical Conditions from the Web Portal: ☐ NONE

☐ Aneurysm - Where:	☐ DVT (Deep Vein Thrombosis)	☐ Kidney Stones
☐ Angina (chest pain)	☐ Emphysema	☐ Metal Allergy
☐ Arthritis - Type:	☐ Epilepsy	☐ MRSA Infection
☐ Asthma	☐ Heart Attack	☐ Pacemaker
☐ Bone or Joint Infections	☐ Hepatitis - Type:	☐ Phlebitis
☐ Cancer - Type:	☐ HIV/AIDS	☐ Pulmonary Embolism
☐ Chemotherapy/Radiation	☐ High Cholesterol	☐ Reaction to Anesthesia - Type:
☐ Breathing Problems / COPD	☐ High Blood Pressure	☐ Seizures
☐ Congestive Heart Failure	☐ Hyperthyroidism	☐ Stomach Ulcers
☐ Diabetes - Type:	☐ Hypothyroidism	☐ Stroke / TIA
Last A1C	☐ Kidney Disease	☐ Tuberculosis
Other:		

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