UMG – Ortho

Electronic Medical Record Patient Chart Preparation

Patient Label

Chief Complaint:_____

Accident related ? ☐ yes ☐ no **Worker's Comp?** ☐ yes ☐ no

☐ Right ☐ Left _____

Duration: _____ **Pain Score: no pain – 0 1 2 3 4 5 6 7 8 9 10 worst pain (circle one)**

Past treatment/ additional providers:_____

_____

Previous Radiology Studies? ☐ **No** ☐ **Yes**

If yes: Dates - Xray_____ **MRI**_____ **CT Scan**_____

Active Medications (List all meds you are currently taking and include herbal, naturopathic or over the counter)

Medication Name	Strength/Directions

Pharmacy 1 Name and Address: _____ Ph:_____

Pharmacy 2 Name and Address: _____ Ph:_____

Allergies (Medications, Environmental, Food): ☐ **No Known Allergies**

Allergy	Reaction	Comments

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Past Medical History: check off all medical problems you have had in your lifetime

☐ AIDS/HIV	☐ Congestive Heart Failure	☐ GERD (reflux)	☐ Multiple Sclerosis	☐ Scoliosis
☐ Alcoholism	☐ COPD (emphysema)	☐ Gout	☐ Myocardial infarction (heart attack)	☐ Seizure disorder
☐ Alzheimer's	☐ Coronary Artery Disease	☐ Hepatitis Type:	☐ Obesity	☐Sleep apnea
☐ Anemia	☐ Crohn's disease	☐ Hyperlipidemia (high-cholesterol)	☐ Osteoarthritis	☐ SLE (lupus)
☐ Angina	☐ Degenerative Joint disease	☐ Hypertension (high blood pressure)	☐ Osteoporosis	☐ Spinal stenosis
☐ Arthritis	☐ Depression	☐Inflammatory bowel disease	☐ Parkinsons	☐ Vertebral Joint disease (Spondyloarthopathy)
☐ Asthma	☐ Diabetes	☐ Juvenile RA	☐ Peptic Ulcer disease	☐ Thyroid disease
☐ Atrial Fibrillation	☐ Drug Abuse	☐ Kidney disease	☐ Psoriasis	☐ Valvular disease (heart valve)
☐ Benign prostatic hypertrophy (prostate enlarged)	☐ DVT	☐ Liver disease	☐ PVD	☐ Other:
	☐ Fibromyalgia	☐ Lyme disease	☐ Renal Disease	☐ Other:
☐ CVA / Stroke	☐ Gallbladder disease	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Other:
☐ Cancer: (date/ type/ treatment)				

Prior Surgeries or Procedures : list all operations you have had in your lifetime

Date:	Type of Operation	Date:	Type of Operation

Family History:

Mother	
Father	
Sister	
Brother	

Tobacco Usage:

☐ **Never Smoked**

☐ **Current Smoker** _____ **packs per day** ____ **yrs** ☐ **Former smoker** - ___ **packs per day** ____ **yrs** **Year Quit** _____

Patient Label

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Review of Systems

Neg	Pos	**Constitutional** ○ **All Neg**
○	○	Chills
○	○	Fatigue
○	○	Fever
○	○	Malaise (uneasiness)
○	○	Night sweats
○	○	Weakness
○	○	Weight gain
○	○	Weight loss
○	○	Other

Neg	Pos	**Heent** ○ **All Neg**
○	○	Blurred vision
○	○	Double vision
○	○	Dysphagia (trouble swallowing)
○	○	Ear drainage
○	○	Facial pain
○	○	Headache
○	○	Hearing loss
○	○	Hoarseness
○	○	Nasal congestion
○	○	Ringing in ears
○	○	Vertigo (dizziness)
○	○	Visual Loss
○	○	Other

Neg	Pos	**Respiratory** ○ **All Neg**
○	○	Chest pain (with breathing)
○	○	Cough
○	○	Dyspena (shortness of breath)
○	○	Known TB exposure
○	○	Resent Infection
○	○	Wheezing
○	○	Other

Neg	Pos	**Cardiovascular** ○ **All Neg**
○	○	Chest pain
○	○	Cyanosis (skin discoloration)
○	○	Heart murmur
○	○	Leg swelling
○	○	Palpitations
○	○	Syncope (fainting)
○	○	Other

Neg	Pos	**Gastrointestinal** ○ **All Neg**
○	○	Abdominal pain
○	○	Black tarry stools
○	○	Constipation
○	○	Diarrhea
○	○	Heartburn
○	○	Jaundice
○	○	Loss of appetite
○	○	Nausea
○	○	Vomiting
○	○	Other

Neg	Pos	**Genitourinary** ○ **All Neg**
○	○	Dysuria(urinary discomfort)
○	○	Frequent Urination
○	○	Hematuria(bloody urine)
○	○	Urge incontinence
○	○	Urinary incontinence
○	○	Other

Neg	Pos	**Metabolic/Endocrine** **All Neg**
○	○	Cold Intolerance
○	○	Hair Loss
○	○	Heat Intolerance
○	○	Other

Neg	Pos	**Neurological** ○ **All Neg**
○	○	Difficulty walking
○	○	Poor coordination
○	○	Memory loss
○	○	Muscle weakness
○	○	Paresthesia (tingling)
○	○	Seizures
○	○	Tremors
○	○	Other

Neg	Pos	**Psychiatric** ○ **All Neg**
○	○	Anxiety
○	○	Depression
○	○	Insomnia
○	○	Other

Neg	Pos	**Musculoskeletal** ○ **All Neg**
○	○	Back pain
○	○	Body aches **where:**
○	○	Bone/Joint pain **where:**
○	○	Rheumatologic Manifestations
		Where:
○	○	Other:

Neg	Pos	**Integumentary** ○ **All Neg**
○	○	Contact allergy
○	○	Itchy Skin
○	○	Rash
○	○	Skin infections
○	○	Skin lesion
○	○	Other

Neg	Pos	**Hematologic Lymphatic** ○ **All Neg**
○	○	Bleeding
○	○	Bruising
○	○	Other

Neg	Pos	**Immunologic** ○ **All Neg**
○	○	Asthma
○	○	Bee sting allergies
○	○	Contact dermatitis
○	○	Environmental allergies
○	○	Food allergies
○	○	Seasonal allergies
○	○	Other

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☐ Chewing Tobacco

Alcohol Usage:

☐ None ☐ Yes : How many days per week _____ How many drinks _____

Substance Abuse:

☐ None ☐ Yes : What substance_____ Last use_____