MOUNT NITTANY PHYSICIAN GROUP

CONFIDENTIAL PATIENT PROFILE
ORTHOPEDICS

The following information is very important to your health. Please take time to fully complete this important information. Please print in black ink or fill in on computer.

Name:_____ Date of service:_____

Address:_____ Apt/#_____

City:_____ State: _____Zip:_____

Date of Birth:_____ Age: _____Height: _____Weight:_____

Sex M: ☐ F: ☐ SSN#:_____ Email:_____

Phone: Home:_____ Work:_____ Cell: _____

Employer:_____ Occupation:_____

Job Physical Function: (ex: lifting, bending)_____

Emergency Contact Name:_____ Phone:_____

Referred by: _____Family Physician _____

Pharmacy & Location:_____

Do you want a copy of your records forwarded to your family physician? Yes: ☐ No: ☐

MEDICAL HISTORY – CHIEF COMPLAINT: PLEASE CHECK THE AREA OF YOUR CURRENT PROBLEM AND WHICH SIDE

☐	Neck		
☐	Upper Back		
☐	Lower Back		
☐	Shoulder	L: ☐	R: ☐
☐	Arm	L: ☐	R: ☐
☐	Elbow	L: ☐	R: ☐

☐	WRIST	L: ☐	R: ☐
☐	HAND	L: ☐	R: ☐
☐	HIP	L: ☐	R: ☐
☐	KNEE	L: ☐	R: ☐
☐	LEG	L: ☐	R: ☐
☐	ANKLE	L: ☐	R: ☐
☐	FOOT	L: ☐	R: ☐

MEDICAL HISTORY: PLEASE **Check** the YES or NO box

Is your current orthopedic problem injury related? ☐ Yes ☐ No If yes- Date of injury:_____

CAUSE of INJURY: Work Accident ☐ Auto Accident ☐ Home Accident ☐ Sports Activity ☐ Other

HISTORY OF PRESENT PROBLEMS Illness/Problems: (PLEASE DESCRIBE THE RECENT EVENTS OF THIS CURRENT ORTHOPEDIC PROBLEM)

Yes	No		Yes	No	
☐	☐	HEART DISEASE	☐	☐	HEMOPHILIA/BLEEDING PROBLEMS/ANEMIA
☐	☐	DIABETES	☐	☐	HIGH BLOOD PRESSURE
☐	☐	MITRAL VALVE PROLAPSE	☐	☐	CANCER TYPE: / LOCATION:
☐	☐	RHEUMATOID ARTHITIS/LUPUS	☐	☐	KIDNEY DISEASE
☐	☐	PROBLEM with ANESTHESIA	☐	☐	HEPATITIS/ LIVER DISEASE
☐	☐	HIV/AIDS	☐	☐	ULCERS/ STOMACH PROBLEMS
☐	☐	THYROID DISEASE	☐	☐	EPILEPSY/ SEIZURES
☐	☐	NERVOUS/MENTAL DISORDER/ DEPRESSION	☐	☐	ASTHMA/ RESPIRATORY DISEASE/TB
☐	☐	VENERAL DISEASE	☐	☐	USUAL CHILDHOOD DISEASE (MUMPS, CHICKEN POX, MEASLES)
☐	☐	BLOOD CLOT/DVT/PULMONARY EMBOLUS			
☐	☐	CHOLESTEROL	☐	☐	Other:

Patients Name:_____ **DOB:**_____

PAST SURGICAL HISTORY: LIST TYPES OF HISTORY

1. _____ 3._____ 5. _____
2. _____ 4. _____ 6. _____

ALLERGIES 1._____ 3._____
to MEDICATIONS 2._____ 4. _____ None ☐

FAMILY MEDICAL HISTORY: (Check any and all that applies to family history)

HEART DISEASE/ STROKE: ☐ DIABETES: ☐ Other:_____

BLOOD CLOTS/DVT/PULMONARY EMBOLISM: ☐ CANCER-Type:_____

SOCIAL HISTORY	
☐	MARRIED
☐	SINGLE
☐	DIVORCED
☐	WIDOW
☐	DOMESTIC PARTNER
☐	CIVIL UNION
☐	SEPARATED
☐	LIVES ALONE

ALCOHOL USE	
☐	1-2 DRINKS/DAY
☐	1-2 DRINKS/WEEK
☐	3 OR MORE DRINKS/DAY
☐	RARELY DRINKS
☐	NEVER DRINKS

☐ # OF CHILDREN

TOBACCO USE	
	# OF YEARS
	PACKS/DAY
☐	CHEW/SNUFF
RECREATIONAL DRUG USE LIST:	

WHICH BELOW DESCRIBES YOUR LIFE STYLE?	
☐	VERY ACTIVE
☐	ACTIVE
☐	MODERATELY ACTIVE
☐	LITTLE ACTIVITY
☐	SEDENTARY (NONE)

REVIEW OF SYMPTOMS: Check ANY symptoms you are experiencing at this time

CONSTITUTION	☐Fever ☐Chills ☐Weight Change ☐Fatigue ☐Headaches	☐None
EAR/NOSE/THROAT	☐Earaches ☐ Sinus Problems ☐ Nose Bleeds ☐Sore Throat ☐ Bleeding Gums ☐Mouth Sores	☐None
CARDIOVASCULAR	☐Chest Pain ☐Heart Problem ☐Heartbeat Changes ☐Swelling in hands & Feet	☐None
RESPIRATORY	☐Asthma ☐Wheezing ☐Shortness of Breath ☐Cough ☐Spitting up blood	☐None
GASTROINTESTINAL	☐Change of bowel movements ☐Vomiting ☐Nausea ☐Heartburn ☐Loss of appetite	☐None
GENITO-URINARY	☐Frequent Urination ☐Painful Urination ☐Blood in Urine ☐Kidney Stones ☐Incontinence	☐None
PSYCHIATRIC	☐Memory Loss ☐ Confusion ☐Depression ☐Sleep Problems	☐None
INTEGUMENTARY	☐Skin Rash ☐Lesions	☐None
NEUROLOGICAL	☐Light-headed ☐ Dizzy ☐Seizures ☐Numbness ☐Tingling ☐Stroke ☐Paralysis ☐Tremor ☐Head Injury	☐None
MUSCULOSKELETAL	☐Joint Pain ☐ Stiffness ☐Weakness ☐ Cramps ☐Muscle Pain	☐None
ENDOCRINE	☐Diabetes ☐ Thyroid Problems ☐ Hot or Cold Intolerance ☐Hormone Problems	☐None
HEMATOLOGIC/LYMPH	☐Easy to Bruise or Bleed ☐Anemia ☐Transfusion ☐Swollen Glands	☐None
IMMUNOLOGIC	☐Immune Deficiency	☐None

THE ABOVE INFORMATION IS CORRECT and WAS FILLED OUT TO THE BEST OF MY ABILITY:

Patient Signature:_____ Date:_____
Parent if Minor

I REVIEWED and DISCUSSED THE ABOVE INFORMATION WITH THE PATIENT:

Physician Signature:_____ Date:_____Time:_____