MOI
Midwest Orthopaedic
INSTITUTE

Name____Age________________Today's Date_______________
Who is your primary doctor? Dr._________________
Who referred you to our office? Dr._________________ ☐ Friend ☐ Family ☐ Workers Comp ☐ Internet
Hospital_____________________ Other: ______________________
Pharmacy: ____________________________ (City) ____

EMPLOYMENT INFORMATION

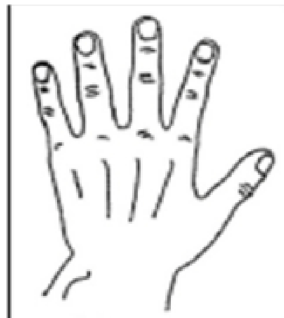
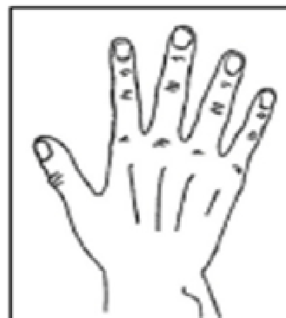
Are you currently employed? ☐ Yes ☐ No ☐ Retired ☐ Student ☐ Permanent Disability
☐ Temporary Disability If **disabled**, for what? _________________________________
Is this a work-related injury? ☐ Yes ☐ No
If working, who is your employer? ____________________________ For how long? ____________________________
Please describe your job (or former job) ____
If you stopped working, when did you stop? ____

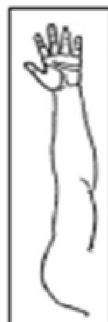
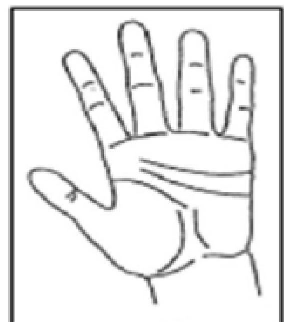
CHIEF COMPLAINT: Why are you seeing the doctor today? ____
Date of injury/When did symptoms begin? ____
If you sustained an injury that caused your symptoms, how did the injury occur? ______________________________
____

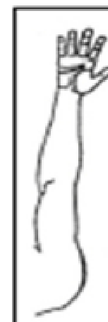
Are you **RIGHT** or **LEFT** handed? ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS – Writes with _____________ hand

On the diagrams below, please identify where your problem is:

LEFT ARM **LEFT HAND** **RIGHT HAND** **RIGHT ARM**



How bad is your pain – **Circle** one number: (not bad) 0 1 2 3 4 5 6 7 8 9 10 (worst pain I've ever had)

Does the pain radiate (move) to other areas? ☐ Yes ☐ No

If yes, where does the pain radiate to? ____
Is your pain: ☐ constant ☐ intermittent

Describe pain: ☐ ache ☐ sharp ☐ dull ☐ stabbing ☐ throb
☐ burning ☐ pressure ☐ numbness ☐ tingly ☐ Other:____________________

What makes the symptoms worse?	☐ work ☐ activity ☐ night ☐ day ☐ temperature changes ☐ Other:___________________________________

What makes the symptoms better?	☐ rest ☐ ice ☐ heat ☐ exercise ☐ wearing splint ☐ Other:_______________ ☐ medication ___________

Are your symptoms getting better? ☐ Better ☐ Worse ☐ Same

Have you ever had this problem or these symptoms before? ☐ No ☐ Yes-Describe ____________________

Treatment	No	Yes	Description	
Splints			Type of splint:	
Therapy			Where?	How often?
Medication			List:	Date last used:
Other:				

Have you ever had tests for this problem? (If you are completing this at home, please bring copies or your test results to the appointment)

Test	No	Yes	When?	Where?
X-Rays				
MRI				
CT Scan				
Nerve Study				
Other:				

YOUR MEDICAL HISTORY:

Condition	No	Yes	Condition	No	Yes
Bleeding Disorder			Thyroid Problems		
Heart Problem			Neurologic Problems		
Breathing Problem			Stroke		
Anesthesia Problem			Cancer		
Arthritis			Diabetes		
Broken bones			High Cholesterol		
Stomach Problems			High Blood Pressure		
Intestinal Problems			Dupuytren's		
Allergies			Gout		
Kidney Problems			Other:		

Please describe if you have answered YES to any of the conditions to the left:

____

____

____

____

____

____

____

SURGICAL HISTORY: Please write down all surgeries you have had. Also the date and doctor if possible.

Surgery	*L/R*	*Doctor*	*Date*

FAMILY HISTORY:

		Major Medical Problems or Cause of Death
Mother:	Alive/Deceased	________________________________
Father:	Alive/Deceased	________________________________
Siblings:	Alive/Deceased	________________________________
	Alive/Deceased	________________________________

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Do you exercise? ☐ Never ☐ Rarely ☐ Daily/Weekly ☐ Monthly

What sporting activities/hobbies do you engage in? ____

Do you smoke? ☐ No ☐Yes--Packs per day?____ Pipes or Cigars per day? ____ **If you stopped –How long ago?** ______

Do you use alcohol? ☐ No ☐ Yes ☐ Social Drinks per day? ______Drinks per week? ______

Do you have a history of substance abuse? ☐ No ☐ Yes –Describe: ______________________________________

Do you currently use a cane, walker, or wheelchair? ☐ No ☐ Yes –Describe: ______________________________

MEDICATIONS:

Please list ALL prescription, over-the-counter, and herbal medications you are taking.

Name of Medication	***Dosage***	***Frequency***	***Reason***

Do you have any **ALLERGIES**? ☐ No ☐ Yes—Please Describe ____

REVIEW OF SYSTEMS:

General	☐ N/A ☐ Chills ☐ Fatigue ☐ Weight loss ☐ Daytime sleepiness
Neuro	☐ N/A ☐ Numbness ☐ Tingling ☐ Headache ☐ Weakness ☐ Stroke
Eyes	☐ N/A ☐ Eye Pain ☐ Eye Pressure ☐ Vision Changes
ENT	☐ N/A ☐ Hearing loss ☐ Lightheadedness ☐ Sinus/ Nasal congestion ☐ Sleep apnea
Respiratory	☐ N/A ☐ Wheezing ☐ Cough ☐ Coughing Blood ☐ Shortness of Breath
Cardiac	☐ N/A ☐ Chest Pain ☐ Palpitations ☐ Awaken short of breath ☐ Ankle swelling
Gastro/Intestinal	☐ N/A ☐ Heartburn ☐ Nausea ☐ Difficulty swallowing ☐ Irritable bowel
Genito/ Urinary	☐ N/A ☐ Menopause ☐ Nausea ☐ Painful urination ☐ Prostate problems
Allergy	☐ N/A ☐ Sneezing ☐ Environmental allergy
Heme/Lymph	☐ N/A ☐ Easy bruising ☐ Sweating at night ☐ Swollen glands ☐ Bleeding problems
Endocrine	☐ N/A ☐ Feel warmer than others ☐ Feel cooler than others
Musculoskeletal	☐ N/A ☐ Joint pain ☐ Joint swelling ☐ Muscle aches ☐ Broken bones
Skin	☐ N/A ☐ Rash ☐ Hives ☐ Itching ☐ Hair symptoms ☐ Skin changes
Psych	☐ N/A ☐ Depression ☐ Anxiety ☐ Panic

Please provide a short explanation for anything checked off in the Review of Systems above: ____________________

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Please provide your current **height** _________ Feet __________ Inches and **weight** __________ Pounds.

Patient/Parent Signature: ___________________________Relation:_____________ Date: ____________