IOWA ORTHO
A CENTER OF EXCELLENCE

Patient History Sheet – Dr. Igram

Account #: ____________________ DOB: ________________________

Date: ____________ Name: ____ Age: ________

Who is your Family/Primary Care Physician? ____

CHIEF COMPLAINT

Why are you seeing the doctor today? ____

Current problem is a result of a (an): Check all that apply.

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other

Date this began bothering you: __________________________

How did the accident happen? ____

Where did the accident happen? ____

What makes it worse? ____

What makes it better? ____

Have you seen any other doctor for this problem? _______ If yes, then who? ____

Have you had any prior treatment for this problem? (surgeon's name and dates) _______________________________________

Have you had any prior treatment for this problem? ______ If yes, please mark the appropriate treatments:

☐ Physical Therapy-Where _____________________________ When? ______________
☐ X-Rays-Where ____ When? ______________
☐ MRI-Where ____ When? ______________
☐ CAT Scan-Where ______________________________________ When? ______________
☐ Injections-Where _______________________________________ When? ______________
☐ Nerve Tests-Where _____________________________________ When? ______________
☐ Other ____________________ Where ____________________ When? ______________

List all current medications and dosage: ____

Do you have any **ALLERGIES** to any medications? ☐ No ☐ Yes List: ____

Are you allergic to latex? ☐ No ☐ Yes

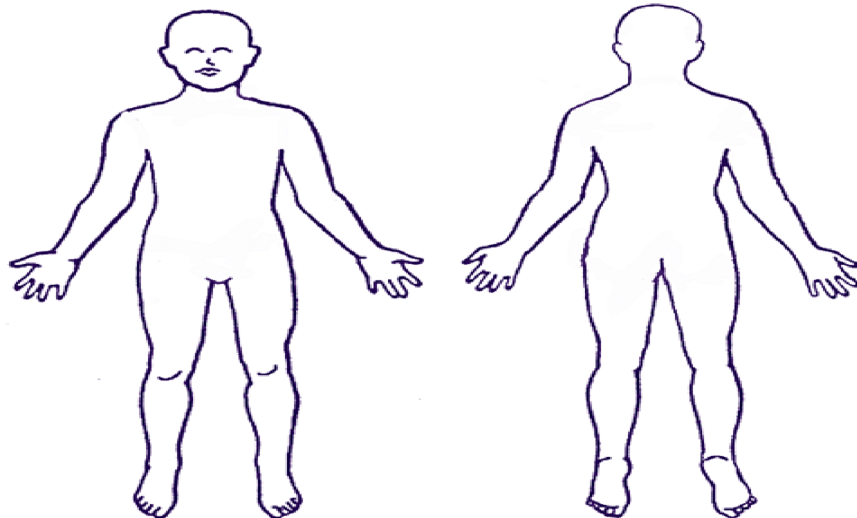
Please shade in the area where your symptoms are on the diagram below

Ache ±

Numbness 0

Pins/Needles _ _ _

Stabbing / / /



IOWA ORTHO
A CENTER OF EXCELLENCE

Patient History Sheet – Dr. Igram

PAST MEDICAL HISTORY

Medical History
Please list any medical problems or accidents:

____
____
____
____
____

Surgical History
Please list any surgeries that you have had and the date:

____
____
____
____
____

Have you ever had general anesthesia? ☐ No ☐ Yes

Have any problems with anesthesia? ☐ No ☐ Yes

SOCIAL HISTORY

☐ Work in the home ☐ Employed (occupation ___________________) ☐ Student ☐ Daycare ☐ Retired

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ No ☐ Yes # _____________

Do you live alone? ☐ No ☐ Yes

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise? ____

History of substance abuse? ____

Smoke currently? ☐ No ☐ Yes Packs per day?_________ for ___________________

Quit smoking? ☐ This year ☐ less than 1 year ☐ less than 5 years ☐ less than 10 years

Previously smoked ________ packs per day for _______ years

Drink alcohol? ☐ Daily ☐ 1-2 times a week ☐ 1-2 times a month ☐ 1-2 times a year

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)				
Grandmother (dad's)				
Grandfather (mom's)				
Grandfather (dad's)				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

IOWA ORTHO
A CENTER OF EXCELLENCE

Patient History Sheet – Dr. Igram

Please indicate if you have experienced any of the following:

Constitutional	Gastrointestinal
☐ Fever	☐ Nausea/Vomiting
☐ Chills	☐ Heartburn
☐ Unusual swelling	☐ Indigestion
☐ Loss of appetite	☐ Constipation
☐ Unexplained weight loss	☐ History of ulcers
☐ Fatigue	☐ Chronic diarrhea
☐ Headaches	☐ Blood in stools
☐ History of cancer	**Genitourinary**
Eyes	☐ Trouble with urination
☐ Blurry vision	☐ Prostate problems
☐ Double vision	☐ Incontinence
☐ Loss of vision	☐ Trouble with erection
☐ Wear glasses/contacts	☐ Loss of interest in sex
Ears/Nose/Mouth	☐ Blood in urine
☐ Trouble hearing	**Musculoskeletal**
☐ Use of hearing aids	☐ Joint pain
☐ Ringing in ears	☐ Osteoporosis
☐ Difficulty in swallowing	☐ Arthritis problems
☐ Drooling	**Neurological**
☐ Loss of smell or taste	☐ Seizures
☐ Voice change	☐ Fainting
☐ Nasal drainage	☐ Dizziness
☐ Bloody noses	☐ Unsteadiness
Cardiovascular	☐ Numbness/tingling
☐ Chest pain	☐ Trouble walking
☐ History of heart attacks	☐ Confusion
☐ History of heart failure	☐ Memory Loss
☐ Palpitations	**Psychiatric**
☐ Irregular heart rhythm	☐ Problems with depression
☐ High blood pressure	☐ Medication for depression
☐ Swollen hands or feet	☐ Manic/depression disorder
☐ Varicose veins	**Endocrine**
Respiratory	☐ Diabetics high blood pressure
☐ Shortness of breath	☐ Thyroid problems
☐ Emphysema	☐ Low blood sugar
☐ Sputum production	**Skin**
Hematologic	☐ Rashes
☐ Bleeding problems	☐ Sores
☐ Bruise easily	☐ Problems with psoriasis
☐ Anemia	☐ Skin tumors removed

Patient's signature: ______________________________________ Date:_______________

Updated 3-28-2010

IOWA ORTHO
A CENTER OF EXCELLENCE

Patient History Sheet – Dr. Igram

History and Physical Examination

Constitutional:

Blood Pressure (sitting) __________ Temp. __________ P (R or Irreg) _________ R _____ HT _____ WT _______

General Appearance (development, habits, deformities, grooming): WDWNA F or M

Skin exam: Surgical Scars ____

Posture: ☐ Scoliosis ☐ Lordosis ☐ Kyphosis

Cardiovascular:

Peripheral

UE- Swelling: Neg/Norm _______ Pos/Abn ____

Pulses: Neg/Norm _______ Pos/Abn ____

Tender: Neg/Norm _______ Pos/Abn ____

LE- Swelling: Neg/Norm _______ Pos/Abn ____

Pulses: Neg/Norm _______ Pos/Abn ____

Tender: Neg/Norm _______ Pos/Abn ____

Varicosity: Neg/Norm _______ Pos/Abn ____

Musculoskeletal:

Gait and Station: Norm ______ Abn ____

Muscle Strength:

RUE: Norm ______ Abn ____

LUE: Norm ______ Abn ____

RLE: Norm ______ Abn ____

LLE: Norm ______ Abn ____

Muscle Tone (note any atrophy or abnormal movements):

RUE: Norm ______ Abn ____

LUE: Norm ______ Abn ____

RLE: Norm ______ Abn ____

LLE: Norm ______ Abn ____

Waddells: _________ of 5

SLR/Lasegue: Sitting R ________ L ________ Supine R ________ L ________

Spurlings: ☐ Right ☐ Left

IOWA ORTHO
A CENTER OF EXCELLENCE

Patient History Sheet – Dr. Igram

History and Physical Examination - Continued

ROM: Neck: Flexion ____________ Extension ____________ Rotation Right ________ Rotation Left _______

Low Back: Flexion____________ Extension ____________ Rotation ___________

Shoulders ____

Hips ____

Knees ____

Sensation: Intact: ________ Abn (identify test and area) ____

DTR (note pathological reflexes):

Uppers: BJ ____________________________________

TJ ____________________________________

RJ ____________________________________

Lowers: KJ ____________________________________

AJ ____________________________________

Coordination: Norm ________ Abn (identify test and extremity, etc) ______________________________________

Tinels ____

Phalens ____

Radiological Tests:

MRI ____ Visualized # of images: _________

CT Scan ____ Visualized # of images: _________

EMG-Report reviewed _________________________________ Visualized # of images:_________

Myelogram and CT ____________________________________ Visualized # of images:_________

X-rays/other: Visualized # of images ____

____

____

 Updated 3-28-2010

IOWA ORTHO
A CENTER OF EXCELLENCE

Patient History Sheet – Dr. Igram

History and Physical Examination - Continued

Impression/Diagnosis:

1. ______________________ Stable Worsening Improved

2. ______________________ Stable Worsening Improved

3. ______________________ Stable Worsening Improved

4. ______________________ Stable Worsening Improved

Recommendations/Counseling/Follow-Up Treatment:

Medication: ______________________

Scans/X-rays: ______________________

Physical Therapy/Exercises: ______________________

Injections: ______________________

Surgery: ______________________

____

☐ I verify that I have discussed with the patient or designee the risks, benefits, options and alternatives to the proposed above operation/procedure.

Other instructions/recommendations: ______________________

____

____

____

If time more than 50% counseling, total time: ☐ 15 min ☐ 30 min ☐ 40 min ☐ 60 min ☐ 80 min

Alternative benefits of procedure/treatments with patient: __________ family: __________

Discussion of findings: __________ Results: ______________________

Discussed with requesting physician: __________ Physician name: ______________________

Follow-up appointment: ______________________

Check here if details are included in dictated notes: __________ X-rays kept? ☐ Y ☐ N

I have reviewed all data in this record and agree.

Signature: ______________________ Date: __________