MAINE MEDICAL PARTNERS – ORTHOPEDICS
Division of Joint Replacements
A department of Maine Medical Center

5 Bucknam Road, Suite 1D • Falmouth, ME 04105
(207) 781-1551 • Fax: (207) 781-1552
www.mainemedicalpartners.org

MEDICAL HISTORY

PLEASE BRING THIS COMPLETED FORM WITH YOU AT THE TIME OF YOUR EVALUATION

Name _____ MR# _____ *(For office use only)* Date of Visit _____

Accurate Height _____ Accurate Weight _____ DOB _____ Age _____

HEALTH CARE PROVIDER NAMES (Primary Care Provider, Cardiologist, Other Specialist): Phone number

1. _____ _____

2. _____ _____

Pharmacy Name _____ _____

ALLERGIES Please list all medications and substances to which you are allergic and the type of reaction you have to the substance.

Allergy	Reaction	Allergy	Reaction
1.		**3.**	
2.		**4.**	

Do you have an allergy/sensitivity to: Latex? ☐ No ☐ Yes **Tape or Adhesives?** ☐ No ☐ Yes *If yes, please explain* _____

CURRENT MEDICATIONS List ALL medications you are using, as well as inhalers, topicals, vitamins, herbals, over-the-counter medications, and use of CPAP.

Medication	Strength	When / How Often	Medication	Strength	When/ How Often
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

MEDICAL HISTORY Current and past medical problems. Example: high blood pressure, history of heart attack, heart problems, blood clot, PE, sleep apnea, hepatitis.

Problem	Problem	Problem
1.	**4.**	**7.**
2.	**5.**	**8.**
3.	**6.**	**9.**

PAST SURGICAL HISTORY List all operations, the most recent first. Please continue on back or on a separate sheet if more room is needed.

Type of Surgery	Date (mm/yy)	Type of Surgery	Date (mm/yy)
1.		**4.**	
2.		**5.**	
3.		**6.**	

Have you had any problems with anesthesia? ☐ No ☐ Yes ☐ N/A *If yes, please explain* _____

Previous EKG: ☐ No ☐ Yes When? _____ Where? _____ Recent Lab Tests: ☐ No ☐ Yes Where? _____

MRSA

Have you had a previous MRSA or staph infection? ..... ☐ Yes ..... ☐ No
If YES, was your last culture? ..... ☐ Positive ☐ Negative
Are you an IV drug user? ..... ☐ Yes ..... ☐ No

Do you currently reside in a skilled nursing facility? ☐ Yes ☐ No
Are you incarcerated? ☐ Yes ☐ No
Are you a dialysis patient? ☐ Yes ☐ No

SOCIAL HISTORY

What type of work do you do? Are you retired or disabled? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, what kind and how much? _____

Do you smoke? ☐ No ☐ Yes If yes, what, and how much? _____

If you used to smoke, how many years did you do so and when did you quit? ☐ N/A _____

Patient Name: _____ DOB: _____ MR#: _____

(For office use only)

Do you exercise regularly? _____ What type of physical activity do you perform regularly? _____

FAMILY HEALTH

Have any blood relatives ever had any of the following? If so, indicate their relationship to you. (e.g., Diabetes - maternal grandmother)

Diabetes _____ Blood Disease/ DVT / PE _____

Heart Trouble _____ Any Unusual Diseases _____

High Blood Pressure _____ Unusual Reaction to Anesthesia _____

If your mother, father, or any of your brothers and/or sisters have died, what was the cause of their death and their age at the time of death?

_____

Who will be taking care of you the after discharge?_____ Reviewed by: _____ Date _____

Have you taken steroids within the last year? ☐Yes…☐No If yes, explain_____

Do you wear dentures? ☐Yes…☐No Do you have an Advance Directive? ☐Yes…☐No If yes, please bring a copy with you.

Below This Line For Office Use Only

CHIEF COMPLAINT _____

HPI _____

X-ray: _____

MRI / CT / US : _____

ROS	WNL	Findings
General	☐	_____
Respiratory	☐	_____
Circulatory	☐	_____
Digestive	☐	_____
Endocrine	☐	_____
Skin	☐	_____
Hematology	☐	_____
OB/GYN/GU	☐	_____
Neurological	☐	_____
Special Senses	☐	_____
Musculoskeletal	☐	_____

PHYSICAL EXAMINATION Pulse _____ Blood Pressure _____/_____ Ht. _____ Wt. _____ BMI _____

General ☐ Well developed, well nourished, in no acute distress _____

HEENT ☐ NCAT ☐ EOMI ☐ Oropharynx Benign _____

Respiratory ☐ CTA Bilat _____

Cardiac ☐ RRR ☐ Ø M/R/G ☐ 2+ UE / LE pulses bilat ☐ Ø carotid bruits bilat. _____

Abdomen ☐ S, NT ☐ Nl BS ☐ Ø HSM or masses _____

Neuro ☐ A+O x 3 ☐ distal sensation intact (affected extremity) ☐ CN II-XII grossly intact _____

Orthopaedic ☐ intact skin ☐ Ø swelling ☐ see chart notes for detailed exam_____

_____

Berlin Score: ☐Positive ☐Negative Referral for further evaluation? ☐Yes…☐No

ASSESSMENT _____

PLAN _____ **Date of Surgery** _____/_____/_____

☐ Informed consent obtained after discussion of the procedure, risks, expected course, and follow-up protocol.

PREP PLAN: NEED FOR FURTHER EVALUTATION BY PREP ANESTHESIA TEAM? ☐Yes…☐No

DVT Prophylaxis: ☐ Compression Hose ☐ Aspirin _____ mg x _____ weeks ☐ Venodyne(s) _____

NOTES _____

☐ It is medically necessary for this patient to have surgery o the same day that the decision for surgery has been made; the patient has been provided a copy of the Patient Rights and Responsibilities brochure prior to surgery and notified of their right the have an Advanced Directive on their chart.

Physician Signature/Date:_____ PA/NP Signature/Date: _____