

Date: _____



Minnesota Orthopaedic Specialists

Patient Update Form (Last 12 months)

Patient Name: _____ Birth date: _____

▶ My Current Height: _____ ft _____ in ▶ My Current Weight: _____ pounds

▶ Allergies (Food, Latex, Tape, Medications, etc.):

▶ Hospitalizations (Where? For what?):

▶ Surgeries (Where? For what?):

▶ Diagnostic Tests (EMG, MRI, CT, BONE SCAN, Lab Tests, etc. Where and when?):

▶ Treatments (Injections, Physical Therapy, New Splints, etc.):

▶ New Medical Conditions:

▶ New Medical Conditions for Primary Family Member (Parent, Brother, Sister or Child):

▶ Medications (Started or Stopped Taking):

▶ Do you take any blood thinners? Yes No

▶ Are you 65 years of age or older? Yes No

▶ Do you have diabetes? Yes No

▶ Have you fallen in the past year? Yes No

▶ Do you take an aspirin every day? Yes No

▶ If you fell, did it result in an injury? Yes No

▶ Do you have kidney disease? Yes No

▶ Have you fallen 2 times in the last year? Yes No

▶ Review of Symptoms: Indicate any of the following symptoms you have had in the past 6 months:

Const: None Fatigue Fever Night sweats Weight gain Weight loss

Cardio: None Chest Pain/Pressure Heart Palpitations (Skipped Beats)

Skin: None Cellulitis Keloid Psoriasis Rash Redness Sores Warmth

Endo: None Excessive Thirst Obesity

GI: None Abdominal Pain Constipation Diarrhea Heartburn Nausea Vomiting

GU: None Kidney Failure Pregnancy

Hema: None Bleeding Blood Clots Bruising

MS: None Back Pain Bone Pain Decreased Range of Motion Joint Locking Joint Pain(s)

Muscle Pain(s) Muscle Weakness Neck Pain Osteoporosis Shooting Pain Swelling

Neuro: None Gait Abnormality Numbness and Tingling

Psych: None Alcohol Abuse Anxiety Depression Drug Abuse Stress

Resp: None Emphysema Shortness of Breath Wheezing

There have been no changes in my medical history

Patient Signature: _____ Date: _____