orthoLA

Confidential Patient Medical History

Updated *07/27/2017*

FOR OFFICE USE ONLY: BORNE ELIAS ELLENDER GREBER HIGGINS HILDENBRAND MORVANT

Height: ____'____" Weight: _____lbs. Age: _____ BP ____/____ Pulse _____ Temp_____

Patient Name: _____ DOB: _____ SSN: _____

Reason for present visit? _____ Affected Side: Left Right Bilateral

Date of Injury: _____ Are you: Right-Handed ? / Left-Handed?

Occupation: _____ Are you currently pregnant? Yes / No

Is this visit related to: Work injury? Yes No Verification of Work Injury Required from employer.
Student athlete injury? Yes No Student Athletic Injury Form Required from school.
Auto injury? Yes No Name of liable party: _____

Pain & Discomfort:

Location: _____ **Type:** _____
Where is the pain/problem? Does it travel to other areas? Is the pain dull, throbbing, sharp? If lump, is it warm, tender, red?

Severity: _____ **Duration:** _____
How severe is the pain on a scale from 1-10 with 10 being the most severe? How long have you had this pain/problem? When did it start?

Timing: _____ **Context:** _____
Does the pain/problem occur at a specific time? Is it rare, intermittent, or constant? What were you doing at the onset of this pain/problem?

Modifying factors: _____
What makes this problem worse or better? (activities)

Past History of *Present* Illness:

Were you referred here by another doctor or therapist for this condition? Yes / No Referred By_____

Have you seen any other physicians regarding ***this*** condition prior to coming to our office? Yes / No

Doctor	When	Tests	Results	Treatment

Have you ever experienced any injury or symptoms regarding this body part before? Yes / No *If yes, provide details:*

List hobbies/activities you enjoy: _____

Which of the above activities are you unable to perform due to your pain? _____

Past Medical History: Have ***you*** *ever* had any of the following? *Circle all that apply.*

ADD	Bladder Infections	DVT (blood clot)	High Blood Pressure	Mitral Valve Prolapse	Sickle Cell
AIDS or HIV+	Bleeding Tendency	Epilepsy	High Cholesterol	Pneumonia	Sleep Apnea
Anemia	Blood Transfusions	Fibromyalgia	Infectious Mono	Polio	Stroke
Arthritis - Osteo	Bronchitis	Glaucoma	Kidney Disease	Restless Leg Syndrome	Thyroid Disease
Arthritis - Rheumatoid	Cancer	Gout	Low Blood Pressure	Rheumatic Fever	Tuberculosis
Asthma	Depression/Anxiety	Heart Disease	Lupus	Scarlet Fever	Ulcers
Back Trouble	Diabetes	Hepatitis	Migraine Headaches	Seizures	

Other: _____

Past Surgical/Hospitalization History

Date	Surgery/Illness	Doctor	Facility

***Current* Medications & Supplements:**

Drug name:	Dosage (mg):	How often do you take?	Date Began Taking:

Preferred Pharmacy: _____ ***Location:*** _____ ***Phone:*** _____

Allergies:

Medication Allergies: _____ Describe Reaction: _____

Food Allergies: _____ Environmental Allergies: _____

Surgical Tape Allergy? Yes / No Latex Allergy? Yes / No

Patient Social History:

Tobacco Use:	Never	Former	Occasional Use	Daily Use _____ (amount)	
Alcohol Use:	None Past Year	1 per day	2-3 per day	4-5 per day	6+ per day
Use of Recreational Drugs:	Never	Previous	Current _____ (list)		
Living Situation:	With Family	With Friends	Live Alone	Nursing Home	Other _____

Family Medical History:

	Known Conditions or Diseases of Immediate Family:	If Deceased, Cause of Death:
Father:		
Mother:		
Siblings:		

Review of Systems:

Please indicate if ***you*** have any of the following– circle all that apply.

Musculoskeletal
Joint Pain
Joint stiffness or swelling
Weakness of muscles or joints
Muscle pain or cramps
Back pain
Cold extremities
Difficulty in walking

Cardiovascular
Hearth trouble
Chest pain or angina pectoris
Palpitation
Shortness of breath while walking
Swelling of feet, ankles or hands

Constitutional Symptoms
Bad general health lately
Recent weight change
Fever
Fatigue
Headaches

Ears/Nose/Mouth/Throat
Hearing loss or ringing
Earaches or drainage
Chronic sinus problems
Nose bleeds
Bleeding gums
Sore throat or voice change
Swollen glands in neck

Genitourinary
Frequent urination
Burning or painful urination
Blood in urine
Incontinence or dribbling

Integumentary (skin, breast)
Rash or itching
Changes in skin color
Varicose veins

Neurological
Light headed or dizzy
Numbness or tingling sensations
Tremors
Paralysis

Endocrine
Excessive thirst or urination
Heat or cold intolerance
Skin becoming dryer

Hematologic/Lymphatic
Slow to heal after cuts
Bleeding or bruising tendency
Anemia
Enlarged glands

Psychiatric
Memory loss or confusion
Nervousness
Depression
Insomnia

Respiratory
Chronic or frequent coughs
Spitting up blood
Shortness of breath
Wheezing

Gastrointestinal
Loss of appetite
Nausea or vomiting
Frequent diarrhea
Constipation
Rectal bleeding, blood in stool
Abdominal pain

Other: Information your doctor might need: _____

Patient verifies that questions on this form have been answered accurately. Patient understands that incorrect information or omissions may be dangerous to his health. It is patient responsibility to inform the doctor of *any* changes in my medical status, prescriptions & insurance information with *each and every* visit. Patient authorizes the health care staff to perform medical testing & treatment.

Signature of Patient or Legal Guardian: _____ Date: _____

Reviewing Physician Signature: _____ Date: _____