



Specializing in Arthroscopic Surgery, Hand Surgery, Foot & Ankle Surgery, Spine Surgery,
Joint Reconstruction, Sports Medicine, Podiatry, Workers Compensation

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PATIENT HISTORY

Date: ____/____/____

Referred by: _____

Patient Name: _____ Date of Birth: ____/____/____

Sex: M F Age: _____ Hand Dominance: R L **Occupation:** _____

PRESENT ILLNESS

Reason for Visit: _____ **Date of onset/injury:** ____/____/____

Mechanism of injury: _____

PAIN: Where does it hurt: _____

Describe the pain: _____

Severity (1-10, 10 being very severe): _____

How often: _____

How has it changed over time: _____

What makes it better: _____

What makes it worse: _____

Associated symptoms: _____

PRIOR TREATMENT: Physician: _____

Medications: _____

Injections: _____

Therapy: _____

Tests/Imaging: _____

Occupational Injury Y N Work Missed: Y N

Last Date Worked: ____/____/____ Date Returned to Work: ____/____/____ with full / light duty

Pharmacy Name and Location: _____

List all current medications: _____

Are you claustrophobic? Mild Moderate Severe No

Drug Allergies and Reaction: _____

Anesthesia Complications: _____

PAST MEDICAL HISTORY Check all that apply

CV: Heart Attack Chest pain Congestive Heart Failure Arrhythmia High Blood Pressure
 Heart Murmur Varicosities Blood Clots

Respiratory: Asthma Emphysema Chronic Bronchitis Pneumonia Asbestos

GI: Ulcers Esophagitis Gastritis Hiatal Hernia Hepatitis GERD

Renal: Kidney Infections Kidney Failure Kidney Stones UTI

Cancer: _____

Hematologic: Anemia Hemophilia Other Bleeding Disorder _____

Endocrine: Hypo Thyroidism Hyper Thyroidism Diabetes Pituitary Gland Disorder

Rheumatologic: Gout Rheumatoid Arthritis Lupus Scleroderma Rheumatic Fever Psoriasis
 Fibromyalgia

DVT Risk Factors: Varicosities Heart Disease HBP Obesity Stroke Previous Blood Clot Diabetes

History of MRSA Y N **or Staph Infection** Y N

PAST SURGICAL HISTORY Please list

FAMILY HISTORY Please include mother, father, siblings, grandparents

Anesthesia Complications: _____

Cardiovascular: _____

Cancer: _____

Hematologic: _____

Musculoskeletal: _____

Renal: _____

Diabetes/Thyroid problems: _____

SOCIAL HISTORY

Tobacco: Current Nonsmoker Former _____ years quit

Alcohol: Frequent Social Occasional Rare None

Illicit Drug Use: Type _____ Amount _____ Frequency _____

Do you have any personal preferences/beliefs that would prevent you from receiving a blood transfusion? Y N

REVIEW OF SYSTEMS Check all that apply

Constitutional: Chills Fevers Night Sweats Weight Loss Weight Gain

Eyes: Near-Sightedness Far-sightedness Astigmatism Double Vision Glaucoma

Ears: Hearing loss Tinnitus Vertigo

Nose, Mouth, Throat: Rhinorrhea Congestion Sore Throat

CV: Chest Pain Heat Palpitations Edema

Respiratory: Cough Wheezing Difficulty Breathing Coughing Blood Shortness of Breath

GI: Nausea Heartburn Bowel Irregularities Hemorrhoids

GU: Frequency Hesitancy Blood in Urine Incontinence Irregular Menstrual Cycle

Musculoskeletal: Muscle Aches Joint Swelling Neck Pain Back Pain

Integumentary: Skin lesions: Stable Changing Acne Rashes

Neurological: Headaches Loss of Consciousness Seizures Tingling Numbness Gait Disturbance

Psychiatric: Depression Mood-swings Hallucinations Anxiety

Endocrine: Excessive Thirst Frequent Urination Hyperactivity Difficulty Sleeping

Hematologic: Easy Bruisability Anemia Bloody Noses Excessive Blood Loss HIV Risk

Height: _____ **Weight:** _____