

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

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PATIENT HISTORY

Date:	_/	_/	Referred by:		
Patient Na	me:		Date of Birth:	/	/
Sex: O M	O F	Age:	Hand Dominance: OR OCcupation:		
			PRESENT ILLNESS		
Reason for	Visit:_		Date of onset/injury:	/	/
Mecha	nism o	f injury:			
PAIN:	Whe	re does it hur	:		
	Desc	ribe the pain:			
	Seve	rity (1-10, 10	peing very severe):		
	How	often:			
	How	has it change	d over time:		
What					
What	makes i	t worse:			
Associ	ated sy	mptoms:			
PRIOR TREATMENT:		ATMENT:	Physician:		
			Medications:		
			Injections:		
			Therapy:		
			Tests/Imaging:		
Occupatio	nal Injı	ury OY O	Work Missed: ○ Y ○ N		
Last Date V	Worked:	:/	_/ Date Returned to Work:/ with full / light duty		
Pharmacy	Name a	and Location	:		
List all cur	rent m	edications: _			
Are you cla	ustropl	nobic? O Mi	ld • Moderate • Severe • No		
Drug Allei	rgies an	d Reaction:			
Anesthesia	Compl	ications:			
NOTES:					

Date:/	Patient Name:
	PAST MEDICAL HISTORY Check all that apply
CV: O Heart Attack O Chest pain O Heart Murmur O Varicositie	○ Congestive Heart Failure ○ Arrhythmia ○ High Blood Pressure
	sema O Chronic Bronchitis O Pneumonia O Asbestos
	stritis • Hiatal Hernia • Hepatitis • GERD ney Failure • Kidney Stones • UTI
Cancer:	·
Hematologic: O Anemia O Hemop	ohilia Other Bleeding Disorder
Endocrine: • Hypo Thyroidism •	Hyper Thyroidism O Diabetes O Pituitary Gland Disorder
Rheumatologic: O Gout O Rheum O Fibromyalgia	atoid Arthritis • Lupus • Scleroderma • Rheumatic Fever • Psoriasis
DVT Risk Factors: • Varicosities	● Heart Disease ● HBP ● Obesity ● Stroke ● Previous Blood Clot ● Diabetes
History of MRSA O Y O N or Sta	ph Infection O Y O N
	PAST SURGICAL HISTORY Please list
FAMIL	Y HISTORY Please include mother, father, siblings, grandparents
Anesthesia Complications:	
Cardiovascular:	
Hematologic:	
Renal:	
Diabetes/Thyroid problems:	
	SOCIAL HISTORY
Tobacco: O Current O Nonsmoke	Former years quit
Alcohol: O Frequent O Social O	Occasional O Rare O None
Illicit Drug Use: Type	Amount Frequency
Do you have any personal preferences	s/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	ghtedness • Astigmatism • Double Vision • Glaucoma
Ears: • Hearing loss • Tinnitus •	Vertigo
Nose, Mouth, Throat: O Rhinorrhe	a O Congestion O Sore Throat
CV: O Chest Pain O Heart Palpitat	ions • Edema
Respiratory: O Cough O Wheezin	g O Difficulty Breathing O Coughing Blood O Shortness of Breath
GI: O Nausea O Heartburn O Box	vel Irregularities • Hemorrhoids
GU: O Frequency O Hesitancy O	Blood in Urine O Incontinence O Irregular Menstrual Cycle
Musculoskeletal: • Muscle Aches	O Joint Swelling O Neck Pain O Back Pain
Integumentary: O Skin lesions: O	Stable • Changing • Acne • Rashes
Neurological: O Headaches O Los	s of Consciousness • Seizures • Tingling • Numbness • Gait Disturbance
Psychiatric: O Depression O Mood	d-swings • Hallucinations • Anxiety
Endocrine: • Excessive Thirst • I	Frequent Urination • Hyperactivity • Difficulty Sleeping
Hematologic: • Easy Bruisability	● Anemia ● Bloody Noses ● Excessive Blood Loss ● HIV Risk
Height: Weight:	