



Patient Information Form & Medical History

This form asks important information that we need to document for medical, legal, and insurance purposes. All information is confidential and kept as part of the medical chart in this office.

Date: ___/___/_____ Primary Care MD: _____ Date of Birth: ___/___/_____

Age _____ Female Male Height ___' / _____" Weight _____ lbs.

Did you bring x-rays or MRI films with you today? Yes No

Have you had x-ray or MRI done elsewhere in the last 3 months? Yes No Where: _____

Who requested that you visit this office? _____ or Self – Referral?

May we send a letter to the referring physician and / or your primary care M.D.? Yes No

What body part(s) is/are involved? (Right / Left / both) _____

Are you right or left handed? Right Left

Can you please describe the nature of your problems?

Have you had a prior problem with this same Orthopaedic condition in the past? (explain below if yes)

How long has this problem been present? _____

Check the ONE box which best fits how your problem started. (Use as much space to the right as needed.)

NO INJURY (for example, arthritis pain) (Onset was: Gradual or Sudden)

Why do you think it started? _____

AUTO ACCIDENT

Date _____ Where and How did it Happen? _____

WORK RELATED

Date _____ Where and How did it Happen? _____

INJURY (other than an auto accident or work injury)

Date _____ Where and How did it Happen? _____

The pain or problem is: Constant Comes and goes (Intermittent)

Severity of pain None Mild Moderate Severe Extremely severe Incapacitating/ worst pain in your life

Patient Printed Name: _____ Page 1 of 3

What is the Quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning Other: _____

Are there associated symptoms? Swelling Numbness Weakness Redness Other: _____

Since your problem started, is it: Getting Better Getting Worse Unchanged

What makes your symptoms worse? Activity Exercise Work Other: _____

Does anything make you feel better? Rest Heat Ice Elevation Other: _____

Have you tried any of the following for this problem?

Brace Cane Crutches Walker Orthotics / prescription shoes

Medications / Other _____

Have you tried physical therapy for this problem? If so, how recently? _____

Have you ever had any **steroid (cortisone) injections** for this problem? If so, how recently?

Have you ever had any **Synvisc, Hyalgan, Supartz, or Euflexxa** injections for this problem?

If so, how recently? _____

ARE YOU A DIABETIC? Yes No

IF DIABETIC, CURRENT TREATMENT: Insulin Oral Medications Diet None

Do you have sleep apnea? Yes No

ARE YOU ALLERGIC TO ANY MEDICATIONS? If so, what happens? _____

ARE YOU ALLERGIC TO ANY FOODS? If so, what happens? _____

(Please check any that apply, or mark None)

	None	Year	Explain	Details/Comments
<input type="checkbox"/> Weight loss <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Fever <input type="checkbox"/> Cancer	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Double Vision <input type="checkbox"/> Cataract <input type="checkbox"/> Blindness	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ringing in Ears	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart condition <input type="checkbox"/> Blood clots	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Short of Breath <input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Blood in Stool	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Pain with Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney disease	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Rash <input type="checkbox"/> Lumps <input type="checkbox"/> Blisters	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Balance Problem <input type="checkbox"/> Headaches	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Depression <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Other psychiatric illness	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia <input type="checkbox"/> Other (describe)	<input type="checkbox"/>	_____	_____	_____

HAVE YOU TAKEN ANY OF THE FOLLOWING FOR THIS PROBLEM: (Circle all that apply)

Advil Ibuprofen/Motrin Lodine Naprosyn Tylenol Ultram/tramadol Celebrex Mobic Aspirin

How long have you taken them? _____

Patient Printed Name: _____

DO YOU EAT A SPECIAL DIET? Yes No Describe: _____

PAST SURGICAL HISTORY: What operations have you had and in what years? None

Have you ever had a reaction to anesthesia? Yes No

If yes, please elaborate: _____

Have you ever had a blood transfusion? Yes No

Did you have any problems with it? _____

FAMILY HISTORY: Have any direct relatives had any of the following disorders?

Diabetes High Blood Pressure Heart disease Arthritis Cancer

Any direct relative with the **same Orthopaedic condition** you are being seen for today?

If direct blood relatives are deceased, can you please describe the cause of death (e.g., mother, father, siblings): _____

Do you currently use tobacco? None Yes : Packs per day _____

Used to smoke, but stopped _____ years ago.

Alcohol use? None Yes: How often? _____

Occupation: _____ Employer: _____

If Student, School: _____ Grade: _____

Are you currently working? Yes No : If **no**, how long have you been off work? _____

If working, can you please describe what's involved? (e.g., heavy lifting, desk work, etc.): _____

FOR WORKMAN'S COMPENSATION CASES ONLY: WC CLAIM #: _____

Date of injury: _____ First date of disability: _____ Last date worked: _____

If out of work now, who has taken you out of work? _____

LEGAL INFORMATION

Do you have any current or pending litigation involving this problem for which we are seeing you today? Yes No

If so, should we expect requests for information from any parties involved? _____

* Everything I have answered is true and correct to the best of my knowledge. I understand that this is a confidential record of my medical history and will be kept in my chart. *Information contained here will not be released without my authorization to do so.*

Patient Signature: _____ Date: _____

Patient Printed Name: _____