GENERAL HISTORY

NAME:____DOB: _______________ DATE:_______________
Please print: First name, middle initial, last name

How old are you? _______ What is your occupation? _______________________ Height _____ Weight _____

Where do you live (City, State)? ____

Who may we thank for your referral to our office? _______________________ Physician or Patient (circle one)

Body part being treated ____Right ____Left _____ Bilateral : ____

On what date did your symptoms begin? ___________________ If unknown how long have you been experiencing difficulty? ____

What do you think may have caused your symptoms (spontaneous, overuse, exercise, accident, work injury)

____

Describe how you were injured: ____

____

Please mark the severity of your discomfort on a scale I-----------------------------------I-----------------------------------I

1 Minimal 5 Moderate 10 severe

What makes your symptoms better? ____

What makes your symptoms worse? ____

How is your injury progressing? ____Getting better ____Staying the same ____Getting worse

Have you been evaluated by: ____Primary Care Physician ____Another Orthopedic Surgeon ____E.R. Visit

Have you had any of the following imaging studies? Please include dates and facility, if known.

____X-ray	date: __________	facility: ______________	____MRI	date: __________	facility: ______________
____CT scan	date: __________	facility: ______________	____EMG/NCV	date: __________	facility: ______________
____Bone scan	date: __________	facility: ______________	_Other__________	date: __________	facility: ______________

Please check any treatments that you tried for your condition?

____Rest	Did it help ____Yes____No	____Ice Application	Did it help ____Yes____No
____Anti-inflammatory	Did it help ____Yes____No	____Cortisone injection	Did it help ____Yes____No
____Exercise	Did it help ____Yes____No	____Acupuncture	Did it help ____Yes____No
____Physical therapy	Did it help ____Yes____No	____Chiropractic	Did it help ____Yes____No
____Brace/Sling	Did it help ____Yes____No	__Other______________	Did it help ____Yes____No

Which of the following symptoms are you experiencing?

____Pain	____Locking/catching	____Weakness	____Instability/slipping sensation
____Stiffness	____Grinding/popping	____Swelling	____Numbness/Tingling
____Aching	____Constant	____Burning	
____Sharp	____Intermittent	____Present only with certain activities	

Does your problem interfere with any of the following?

____ Daily activates ____ School Activities ____Work activities ____Recreation or Sports ____Sleeping

Have you ever had any significant injuries or required surgery in the past? ____Yes____No

If Yes, please explain and list prior dates, physicians, and any procedures: ______________________________

____

____

Name: ______________________ Date of Birth: ____________ Date: ____________

Tobacco Use _____ None

____ Cigarette
____ Cigar
____ Pipe
____ E-Cig
____ Smokeless Tobacco

____ Current Daily Smoker
____ Current Someday Smoker
____ Former Smoker
Approx Yrs. Smoked ________
Quit Date ______________
____ Unknown

Interested in Quitting?
Y N

Surgical History: _____ None _____ Other: ______________________

____ Ankle Surgery
____ Back Surgery
____ Elbow Surgery
____ Foot Surgery
____ Hand Surgery
____ Heart Surgery
____ Hip Surgery
____ Joint Replacement
____ Lung Surgery
____ Knee Surgery
____ Shoulder Surgery
____ Wrist Surgery

Medical History: _____ None _____ Other: ______________________

____ Anesthetic Complications
____ Arthritis
____ Asthma
____ Baker's Cyst
____ Bleeding Disorder
____ Blood Clots
____ Bursitis
____ Cancer:
Describe______________
____ COPD or Emphysema
____ Diabetes
____ Heart Disease
____ Hepatitis: A, B, C
(Please Circle One)
____ High Blood Pressure
____ HIV
____ Irregular Heartbeat
____ Liver Disease
Describe______________
____ Osteoarthritis
____ Osteoporosis
____ Paget's Disease
____ Rheumatologic Disease
____ Seasonal Allergies
____ Seizure
____ Stroke
____ Thyroid Disorder
Describe______________

Family History: ______ None Please Check Below for All That Apply To Your Family Members

Please state the relationship: ___ Mother ___ Father ___Brother ___ Sister ___ Other:______________
_____ Anesthetic Complications _____ Broken Bones _____ Cancer _____ Clotting Disorder
_____ Diabetes _____ Dislocations _____ Osteoporosis _____ Rheumatologic Disease
Please give specifics:
____

Alcohol Use: _______None

Number of Drinks Per Week
____ Wine ____ Beer ____ Liquor

Drug Use: ______ None

____ Marijuana _____ Cocaine
____ Methamphetamines

Preferred Language: _____ Refused

____ English _____ Other __________

Ethnicity: _____ Refused

_____ Hispanic ______ Non-Hispanic
_____ Unknown

Race: _____ Refused

_____ White _____ Black _____ More Than One Race
_____ Asian _____ American Indian and Alaska Native _____ Unknown
_____ Pacific Islander and Hawaii Native _____ Other ______________

Name: ______________________________ Date of Birth: ______________ Date: ____________

Allergies:	_____ None	Are you allergic to Latex? Y or N

Current Prescribed and Over The Counter Medications:		
Medication Name	Dosage and Frequency	Used For?

Current Preferred Pharmacy:		
Store Name	Address or Cross Streets and City	Phone Number

CONSTITUTION: None	EYES: None	GASTROINTESTIONAL: None	ENDO/Heme/Aler: None
Chills	Blurred Vision	Heartburn	Easy bruise/bleed
Weight loss	Double Vision	Nausea	Env Allergies
Fatigue	Photophobia	Vomiting	Polydipsia
Diaphoresis	Eye pain	Abdominal pain	NEUROLOGICAL: None
Weakness	Eye Discharge	Diarrhea	Dizziness
SKIN: None	Eye Redness	Constipation	Tingling
Rash	CADIOVASCULAR: None	Blood in Stool	Tremor
Itching	Chest Pain	Melena	Sensory Change
	Palpitations	GENITOURINARY: None	Speech Change
HENT: None	Orthopnea	Dysuria	Focal Weakness
Headaches	Leg Swelling	Urgency	Seizures
Hearing loss	PND	Frequency	LOC
Tinnitus		Hematuria	PSYCHIATRIC: None
Ear pain	RESPIRATORY: None	Flank Pain	Depression
Ear discharge	Cough	MUSCULOSKELETAL: None	Suicidal Ideas
Nosebleeds	Hemoptysis	Myalgias	Substance Abuse
Congestion	Sputum production	Neck Pain	Hallucinations
Stridor	Shortness of breath	Back Pain	Nervous/Anxious
Sore Throat	Wheezing	Joint Pain	Insomnia
		Falls	Memory Loss