Texas Health Orthopedic Specialists

Texas Health Orthopedic Specialists Patient History Form

Name:_____ **Nickname:**_____ **Today's Date:**_____

Date of Birth:_____ **Age:**_____ **Height:**_____ **Weight:**_____

History of Injury

Is this related to a: ¨ Work injury? ¨ Motor vehicle accident? If so, what state?_____ or ¨ Sport accident?

Which body part is injured?_____ ¨Right / ¨Left **Hand dominance:** ¨Right / ¨Left

Please list the injury/accident date:_____ **If chronic list how long:**_____

Please describe in your own words: (How the initial injury occurred and how it limits your activity)

_____

_____

_____

_____

Please rate your pain on a scale of 1 to 10: (10 being the most painful)

Rest: 0 1 2 3 4 5 6 7 8 9 10 **At its worst:** 0 1 2 3 4 5 6 7 8 9 10

Is the pain: ¨Constant or ¨Occasional **Has it been:** ¨Worsening ¨Stable ¨Improving

Describe the pain: ¨Sharp ¨Dull ¨Aching ¨Stabbing ¨Throbbing ¨Sensitive to Touch

Do you have pain at night? ¨Yes / ¨No **Does the pain keep or wake you from sleep?** ¨Yes / ¨No (¨Keep ¨Wake)

What symptoms are you experiencing?

¨Locking ¨Catching ¨Giving Way/Instability ¨Popping ¨Grinding ¨Bruising ¨Numbness ¨Tingling

¨Pain ¨Weakness ¨Swelling Other (Please describe):_____

What, if anything, makes your symptoms better?

¨Rest ¨Activity ¨Cold Therapy ¨Heat Therapy ¨Medication ¨Other (Please describe):_____

What, if anything, makes your symptoms worse?

¨Inactivity ¨Exercise (Describe):_____ Other (Please describe):_____

What treatment have you tried for this injury?

¨Nothing ¨Exercise ¨Ice ¨Decreased Activity ¨Bracing

¨Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started):_____

¨Physical Therapy (Date Started):_____ ¨Acupuncture (Date Started):_____ ¨Other: _____

¨Medications:_____ ¨Chiropractic (Date Started):_____

Have you seen another physician for this injury? ¨Yes / ¨No **Were you referred?** ¨Yes / ¨No

If yes, who/where? _____

Are you interested in surgery for this problem? ¨Yes / ¨No / ¨Unsure

Have you had any of the following tests/studies?

Test	Date (Month/Year)	Facility? (Clinic/Hospital)
X-Ray		
CT Scan		
EMG/NCV		
Discogram		
EKG		
Blood Tests		
Other		

PAST MEDICAL HISTORY Please check if you currently suffer or have previously suffered from:

	When?		When?
High Blood Pressure		Osteoporosis	
Deep Vein Thrombosis (Blood Clot)		Kidney Disease/Problem	
Liver Disease		Seizures	
Heart Disease/Attack		Arthritis	
Stroke		Thyroid ¨ Hyper ¨ Hypo	
Cancer (Where?)		Tuberculosis	
Elevated Cholesterol		Pulmonary Embolism	
Ulcer Disease		Polio	
Gastritis		Rheumatic Fever	
Reflux Disease (GERD)		Gout	
Asthma		Depression	
Diabetes		Psoriasis	
History of MRSA		COPD	
Other:		Sleep Apnea	

Do you have a pacemaker? ¨Yes / ¨No **Have you ever had heart, brain or artery surgery?** ¨Yes / ¨No
Do you have any chance of implants or metal shavings in your skin? ¨Yes / ¨No

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? ¨Yes / ¨No If Yes, When?_____
Do you have a history of GI, stomach bleed? ¨Yes / ¨No If Yes, When?_____

Do you take any medications for your stomach? (Please include over the counter medications; i.e. Pepcid, Tums, Zantac, etc. dose and frequency)

_____

SURGICAL HISTORY

Please list all surgeries to the area you are being seen for today:

Type of Surgery	Date	Surgeon

Please list all other surgeries you have had in the past:

Type of Surgery	Date	Surgeon

Have you ever had a reaction to anesthesia? ¨Yes / ¨No If yes explain:_____

ALLERGIES

Are you allergic to: **Sulfa Drugs?** ¨Yes / ¨No **Latex?** ¨Yes / ¨No **Steroids?** ¨Yes / ¨No

Please list any environmental allergies:

Other Medication Allergies	What Happened?

MEDICATIONS (Please list all prescription, over the counter medications and supplements)

Medication	Dosage	Frequency

SOCIAL HISTORY

Occupation:_____ Are you currently working? ¨Yes ¨No ¨Retired ¨Limited Duty

Recreational activities:_____ ¨College or ¨Pro?

Current activity level:_____

Tobacco product use: ¨Never ¨Smoke ¨Chew **Freq:** ¨Everyday ¨Someday ¨Occasionally ¨Former ¨Unknown

Alcohol use (Drinks per day): ¨6 or More ¨4-5 ¨2-3 ¨1 ¨Less than 1 ¨0 In last year ¨Don't drink

Caffeine use: ¨Yes ¨No Type/Frequency:_____

Recreational drugs: ¨Yes ¨No Type/Frequency:_____

Is there a chance you could be pregnant? ☐Yes / ☐No

FAMILY HISTORY (Please check family history conditions as well as who had the condition)

Blood Clots:_____ Osteoporosis:_____ Rheumatoid Arthritis:_____

Diabetes:_____ Heart Disease:_____ Hypertension:_____

Seizures:_____ Stroke:_____ Anesthetic Problems:_____

Cancer: _____ Other:_____

REVIEW OF SYSTEMS

CONSTITUTIONAL/GENERAL ¨None ¨Weight Gain ¨Weight Loss ¨Chills ¨Fever ¨Weakness/Fatigue
Other:_____

EYES ¨None ¨Blurred Vision ¨Glasses ¨Contacts ¨Eye Pain ¨Redness
¨Vision Change ¨Cataracts ¨Glaucoma
Other:_____

EARS, NOSE, THROAT ¨None ¨Nose Bleed ¨Ear Ache or Infection ¨Ringing in Ear ¨Hoarseness
¨Loss of Hearing
Other:_____

CARDIOVASCLAR ¨None ¨Chest Pain ¨Swelling in Legs ¨Shortness of Breath ¨Palpitations
Other:_____

RESPIRATORY ¨None ¨Shortness of Breath ¨Wheezing/Asthma ¨Frequent Cough
Other: _____

GASTROINTESTINAL ¨None ¨Heartburn ¨Vomiting ¨Nausea ¨Abdominal Pain ¨Acid Reflux
Other:_____

MUSCULOSKELETAL ¨None ¨Arthritis ¨Stiffness ¨Muscle Aches ¨Swelling of Joints ¨Instability
Other:_____

SKIN ¨None ¨Rash ¨Itching ¨Redness ¨Abnormal Scars ¨Psoriasis ¨Ulcers/Sores
Other:_____

NEUROLOGICAL ¨None ¨Headaches ¨Numbness, Tingling, Loss of Sensation in ANY Body Part
¨Dizziness ¨Poor Balance ¨Fainting Spells ¨Seizures
Other:_____

PSYCHIATRIC ¨None ¨Depression ¨Nervousness ¨Anxiety ¨Mood Swing
Other:_____

ENDOCRINE ¨None ¨Excessive Thirst or Hunger ¨Hot/Cold Intolerance ¨Hot Flashes
Other:_____

HEMATOLOGICAL ¨None ¨Easy Bruising ¨Easy Bleeding ¨Varicose Veins ¨Blood Clots ¨Anemia
Other:_____

Signature:_____ Date:_____

Print Name:_____