Orthopedic Specialists & Sports Medicine

KEEPING YOU ACTIVE

Patient History Form

Name: ______________________ Date of Birth: ______________ Today's Date: ______________

What pharmacy do you use? ______________________

SOCIAL HISTORY

Employment	Marital Status	Home Environment
Occupation: ______________	❒ Married	❒ Lives Alone
❒ Work in the Home	❒ Single	❒ Lives With Spouse
❒ Student	❒ Divorced	❒ Lives With Children
❒ Disabled	❒ Separated	❒ Lives With Friend
❒ Retired	❒ Widowed	Other: ______________
❒ Unemployed		

Advance directives of patients will be honored, within a context appropriate to an orthopedic practice. These include a living will, durable power of attorney, and DNR (do not resuscitate) orders. Please provide us with a copy.

Do you have a history of substance abuse? ❒ No ❒ Yes Describe: ______________________

Smoking	Alcohol
Do you currently smoke? ❒ No ❒ Yes	Do you drink alcohol? ❒ No ❒ Yes
How many packs per day? _____ How many years? _____	If yes, what type? ❒ Beer ❒ Wine ❒ Hard Liquor
If you were a smoker and have quit, how long ago did you quit? ❒ This Year ❒ >1 Year ❒ >5 Years ❒ >10 Years	❒ Other: ______________________
Amount Previously Smoked: Pack(s) Per Day: __________	How many drinks per week do you drink? _____
How many years did you smoke then? __________	

FAMILY HISTORY

Check All That Apply (Does Not Include You)

❒ Anesthesia Problem
❒ Heart Problems
❒ Cancer
❒ Breathing Problems
❒ Tuberculosis
❒ Diabetes
❒ Bleeding Disorders
❒ High Blood Pressure
❒ Other: ______________

Member	Living	Deceased	Age	List Any Health Problems or Cause of Death
Father				
Mother				

MEDICATIONS

Please list all medications you are taking, including any over-the-counter and herbal supplements.

Medication	Dose	Medication	Dose

ALLERGIES

Drug	Type of Reaction	Drug	Type of Reaction

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PREVIOUS SURGERY

Please check all that apply and fill in the year that the surgery occured.

❒ Appendectomy: ________	❒ Hysterectomy: ________	❒ Gall Bladder: ________
❒ Hernia Repair: ________	❒ C-Section: ________	❒ Hemorrhoidectomy: ________
❒ Bowel Surgery: ________	❒ Prostate: ________	❒ Bladder: ________
❒ Tubal Ligation: ________	❒ Vasectomy: ________	❒ Open Heart-Bypass: ________
❒ Open Heart-Valve: ________	❒ Other Vascular Surgery: _______	❒ Pacemaker: ________
❒ Breast Biopsy: ________	❒ Tonsil & Adenoidectomy: _______	❒ Cataract or Eye: ________
❒ Tooth Extraction: ________	❒ Craniotomy: _______	❒ Organ Transplant: ________
❒ Foot Surgery: ________	❒ Arthroscopic: _______	❒ Total Joint Replacement: ________
❒ Other: ______________________		

Have you had a pneumonia vaccine in the past? ❒ No ❒ Yes Where/When:______________________

Have you had a flu vaccine in the past? ❒ No ❒ Yes Where/When:______________________

PAST OR PRESENT DISEASE HISTORY

Please check all that apply and give the approximate date it occurred.

❒ Diabetes: ________	❒ Cancer: ________	❒ Hepatitis, Type: ________
❒ Poor Circulation: ________	❒ Pneumonia: ________	❒ Liver Disease: ________
❒ Foot Ulcer: ________	❒ Tuberculosis: ________	❒ Fibrosis: ________
❒ Delayed Wound Healing: ________	❒ Asthma: ________	❒ Lupus: ________
❒ Wound Infection: ________	❒ Emphysema: ________	❒ Scoliosis: ________
❒ Phlebitis: ________	❒ Persistent Cough: ________	❒ Osteoarthritis: ________
❒ Pulmonary Embolism: ________	❒ HIV Positive: ________	❒ Rheumatoid Arthritis: ________
❒ Heart Trouble: ________	❒ AIDS: ________	❒ Psoriasis: ________
❒ Heart Attack: ________	❒ Anxiety: ________	❒ Gout: ________
❒ High Blood Pressure: ________	❒ Depression: ________	❒ Polio: ________
❒ Thyroid Disorder: ________	❒ Sexually Transmitted Disease: ________	❒ Fractures: ________
❒ Stroke: ________	❒ Bleeding Disorder: ________	❒ Recurrent Sprains: ________
❒ Seizure Disorder: ________	❒ Stomach Ulcer: ________	❒ Neck or Back Pain: ________
❒ Malaria: ________	❒ Kidney Disease: ________	❒ Other: __________________________

Patient Signature: ____ Date: ____________

Physician Signature: ______________________________________ Date: ____________

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Workers' Compensation Claim

Have you contacted your employer regarding this claim? ❒ No ❒ Yes

How did the injury happen?

____

____

____

Date of Injury: __________________

Where did it happen? Please complete in detail (which place of employment if there are two, was it in the parking lot or in the break room, how it happened, etc.).

____

____

____

What is your Workers' Compensation Claim Number (if known)? ____

At your place of employment, who do we contact regarding this claim?

____

What is your allowed diagnosis (if known)? ____

Please provide your BWC claim card at each visit pertaining to this claim. If you do not have a current claim number, please provide your medical insurance card. If you need to be seen for another problem, a separate appointment must be made.

Orthopedic Specialists & Sports Medicine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.