

SOUTHERN ORTHOPEDICS & SPORTS MEDICINE

Patient History Form

PLEASE PRINT CLEARLY

Name _____ Date of Birth _____

Reason for visit: _____ LEFT RIGHT BOTH

Is injury due to recent auto accident? ____ YES ____ NO Date of Injury _____ Time _____

Referring Provider _____ Pregnant? YES NO POSSIBLE

Have you had recent X-RAYS/MRI YES NO Where? _____

Any allergies and the reactions _____

Current Medications and Dosage

_____	_____
_____	_____
_____	_____
_____	_____

Are you currently experiencing any of the following? (Please check)

- | | | |
|--|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Vision Loss |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Palpitation | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Cold/Hot intolerances | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Rash/Skin Problems | <input type="checkbox"/> Abnormal Bleeding |

Past and present medical problems (please check)

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypertension (High Blood Pressure) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperlipidemia (High Cholesterol) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Juvenile/Adult Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer-Type _____ | <input type="checkbox"/> DVT | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cerebrovascular Accident (Stroke) | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Gout | <input type="checkbox"/> Myocardial Infarction (Heart Attack) |
| <input type="checkbox"/> Other _____ | | |

NAME _____ Date of Birth _____

List any surgeries with the approximate date _____

Have any of your parents, siblings or grandparents had a history of (Please check)

Hypertension Myocardial Infarction (Heart Attack) Cancer-Type _____
 Diabetes Hyperlipidemia (High Cholesterol) Cerebrovascular Accident (Stroke)

Do you: (PLEASE CIRCLE)

Drink alcohol YES NO Exercise Level NONE MODERATE VIGOROUS

****PLEASE FILL OUT SMOKING/TOBACCO SECTION****

1. Smoke or use tobacco? CURRENT FORMER NEVER UNKNOWN

Type of tobacco: _____

Units/day: _____ Years used: _____ Pack Years: _____

2. Ever tried to quit: YES NO Years quit: _____ Longest tobacco free: _____

Relapse Reason: _____

3. Passive smoke exposure (second-hand smoke): NO YES

Patient Signature: _____ Date: _____