

GREATER AUSTIN ORTHOPAEDICS

PATIENT MEDICAL HISTORY

Today's Date: _____

Name: _____

Age: _____

Sex: M / F

Marital Status: Married / Single / Partnered

Right-handed / Left-handed

Height: _____

Weight: _____

Chief Complaint: _____

Please describe complaint: _____

How long has this occurred?: _____

Referring Physician: _____

Was this an injury?: No Yes (If yes, please list date of injury: _____)

Were you injured at work?: No Yes

Were you involved in a motor vehicle accident?: No Yes

If yes, do you have an attorney?: No Yes

If yes, what is your attorney's name?: _____

Pain & Symptoms: (Please mark all boxes that apply to current chief complaint.)

Numbness & Tingling

Trouble Sleeping

Radiating Pain

Joint Catch/Locking Episodes

Swelling

Limited Range of Motion

Trouble Walking

Trouble Sitting

Trouble Lying Down

Bowel/Bladder Problems

Are you currently under the care of a pain management specialist? No Yes

Past Medical Treatment: (Please mark all boxes that apply to current chief complaint.)

Pain Medication

Physical Therapy

Rest

Anti-Inflammatory Medication

Chiropractic Therapy

Splinting

Muscle Relaxers

Cortisone Injections

Casting

Oral Steroid Medications

CT/Myelogram

Bracing

Discogram

X-Rays

Bonescan

Lumbar Epidural Steroid Injections

Nerve Root Blocks

MRI

Cervical Epidural Steroid Injections

Past Medical History: (Please mark all boxes that apply to you.)

Asthma

Diabetes

Fainting Spells

Heart Attack (Age: _____)

Heart Trouble (If yes, please list cardiologist: _____)

Convulsions

Tuberculosis

Cancer (Type: _____)

Stroke

High Blood Pressure

Epilepsy

Rheumatoid Arthritis

Lupus Disease

Reiter's Disease

Bleeding Disorder

Migraine Headaches

Alcoholism

Emphysema

Stomach Ulcers

Birth Defects

Metal Implants

HIV Infection

Hepatitis A, B, or C

Any other serious disease, or illness? (Please list)

Current Medications:

Prescribed:

Over The Counter:

Herbal:

Drug Allergies:

Are you pregnant, or think that you might be pregnant?: No Yes

Please List All Surgeries That You Have Had:

Social History: (Please answer all that apply to you)

Do you have children?: No Yes

Do you smoke?: No Yes (How much & for how long?: _____)

Do you drink alcohol?: No Yes (How many drinks & for how long?: _____)

Do you use recreational drugs?: No Yes

Do you exercise?: No Yes (How often? _____ Times per week/month)

Family History: (Please mark all that apply to you)

High Blood Pressure Heart Disease Anemia Arthritis Lung Disease Gout

Depression Mental Illness Diabetes

Cancer (Please list what type/s: _____)

Recent Health: Have you had any of the following symptoms?: (Please mark all that apply to you)

General: Fever Chills Night Sweats Loss of Appetite Nausea/

Vomiting

Skin Changes Fatigue Changes in Weight Trouble Sleeping

Eyes: Glasses/Contacts Double Vision Blurred Vision Glaucoma Cataracts Date of

last eye exam: _____

Ears:

Hearing Loss Hearing Aid Popping Infection Ringing Dizziness

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Cardiovascular:

- Chest Pain Palpitations Pain on Exertion Murmur Rheumatic Fever
 Edema Fainting Thrombophlebitis Lightheadedness

Respiratory:

- Cough Sputum Shortness of Breath Emphysema COPD
 Coughing up Blood Asthma Bronchitis Tuberculosis Pleurisy

Gastrointestinal:

- Pain Heartburn/GERD Indigestion/Gas Nausea/Vomiting Diarrhea
 Constipation Food Intolerance Use Laxatives Vomiting Blood Peptic Ulcers
Blood/Mucus in Stool Hemorrhoids Hernia Polyps Colitis
 Diverticulosis/Diverticulitis

Endocrine:

- Hot Flashes Hair Loss Excessive Thirst Goiter Hypothyroid Hyperthyroid
 Temperature Intolerance

Hematological/Lymphatic:

- Easily Bruised DVT Anemia Past Transfusion Swollen/Painful Lymph Nodes

Allergic/Immunologic:

- Reoccurring Infections Allergies Hives HIV Immunoglobulin Deficiency

Musculoskeletal:

- Joint Pain Back Pain Stiffness/Arthritis Gout Muscle Pain Swelling Redness

Neurological:

- Numbness Tingling Fainting Poor Balance Seizures Paralysis/Paresis
 TIA/Stroke Memory Loss

- Psychiatric:** Anxiety Depression Nervousness Bipolar Disorder Schizophrenia

Insomnia

Are you currently receiving therapy/counseling? No Yes

Patient Signature

Date