

Initial Patient Health History Form

Western Orthopaedics, PC

NAME: _____

Age: _____ **Today's Date:** _____

Date of Birth: _____ **Marital Status:** _____

Occupation/Job: _____

Did another Doctor send you to us? Yes / No
If yes, please give name and address of physician:

Where is your problem? (please circle)

Ankle Knee Hip Elbow

Shoulder Back Wrist Other

Which Side? Right / Left / Both

Dominant Arm? Right / Left

Problems (please check all that apply)

- ☐ Pain?
- ☐ Weakness?
- ☐ Instability/Giving way/Dislocation?
- ☐ Stiffness?
- ☐ Swelling?
- ☐ Other? _____

How did you injure yourself?

- ☐ No injury, just started hurting
- ☐ Sports (which sport?) _____
- ☐ Motor vehicle accident
- ☐ Work / Job

Is there a workers comp claim? Yes / No

Date of Injury? _____

How long have you had Symptoms? _____

Briefly describe your injury:

Diagnosis (if you know or have been told?)

Previous Treatments (medications, Physical Therapy, Injections, bracing, or surgery) _____

Sports Level: None / Recreational / Competitive

Practitioner's Initials and Date: _____

Previous Surgeries (include dates): _____

How severe is the Pain (0= none, 10= severe pain)

At 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

Do you have pain at night? Yes / No

Does it waken you from sleep? Yes / No

Is the pain getting:

Better

Worse

Same

What makes your problem better? _____

What makes your problem worse? _____

Are you currently working? Yes / No / Retired

☐ Normal Job

☐ Limited Duty

Please describe your current limitations? _____

Have you had any Imaging Studies?

X-rays Yes / No Date: _____

MRI Yes / No Date: _____

Cat Scan Yes / No Date: _____

Allergic to Latex? Yes / No

Allergies to Medications or foods? _____

Please list your medications, the dose and frequency:

Do you take Aspirin? Yes / No

Do any diseases run in your family? _____

Medical History (Please circle)

Do/Did you have high blood pressure? Yes / No

Do/Did you have any heart problems? Yes / No

Do/Did you have ulcers or gastritis? Yes / No

Do/Did you have Diabetes? Yes / No

Do/Did you have liver problems/Hepatitis? Yes / No

Do/Did you have kidney disease? Yes / No

Do/Did you have Cancer? Yes / No

Do/Did you smoke or chew tobacco? Yes / No

Do you have HIV or Hepatitis C? Yes / No

Did you ever have a Blood clot or embolus? Yes / No

CONTINUED ON REVERSE SIDE

Initial Patient Health History Form

Additional Medical Questions:

1. Have you ever had RSD (Reflex Sympathetic Dystrophy)? Yes / No
2. Do you have Sleep Apnea? Yes / No If yes, what do you use: _____
3. Did you ever have a significant joint or bone infection? Yes / No
If yes, please explain: _____
4. Have you ever been told that your family is predisposed to blood clots? Yes / No

Review of Systems:

1. **Constitutional/General** ☐ None ☐ Recent Weight Change ☐ Chills ☐ Fever ☐ Weakness/Fatigue
☐ Other: _____
2. **Eyes** ☐ None ☐ Vision change ☐ Glasses/Contacts ☐ Cataracts ☐ Glaucoma
☐ Other: _____
3. **Ear, Nose, Throat** ☐ None ☐ Hearing Loss ☐ Ear ache or infection ☐ Ringing in ear
☐ Other: _____
4. **Cardiovascular** ☐ None ☐ Chest Pain ☐ Swelling in Legs ☐ Palpitations
☐ Other: _____
5. **Respiratory** ☐ None ☐ Shortness of Breath ☐ Wheezing, Asthma ☐ Frequent Cough
☐ Other: _____
6. **Gastrointestinal** ☐ None ☐ Acid Reflux ☐ Nausea or Vomiting ☐ Abdominal Pain
☐ Other: _____
7. **Musculoskeletal** ☐ None ☐ Muscle Aches ☐ Swelling of the Joints ☐ Stiffness in Joints
☐ Other: _____
8. **Skin** ☐ None ☐ Rash ☐ Ulcers ☐ Abnormal Scars
☐ Other: _____
9. **Neurological** ☐ None ☐ Headaches ☐ Dizziness ☐ Numbness, tingling, loss of sensation
☐ Other: _____
10. **Psychiatric** ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swings
☐ Other: _____
11. **Endocrine** ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot flashes
☐ Other: _____
12. **Hematologic** ☐ None ☐ Easy Bruising ☐ Easy Bleeding ☐ Anemia
☐ Other: _____

Height: _____

Weight: _____

What activities would you like to do if you were not injured or in pain?

Signature: _____ Date: _____

Name: _____

Practitioner's Initials and Date: _____