WESTERN ORTHOPAEDICS
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PATIENT HISTORY FORM

Name _____ DOB _____ Date _____

Height _____ Weight _____ Age _____

Who referred you to us? _____

Who is your primary care physician? _____

Date of injury of accident _____ Type of Accident W/C ❑ Auto ❑ Other ❑

Were X-rays taken? _____ Yes ❑ No ❑ Where? _____

Date stopped work (if applicable) _____ Date returned to work _____

Area of body injured _____ Right ❑ Left ❑

How injury/illness happened/reason for today's visit: _____

_____

Have you had any other treatment for this problem? Yes ❑ No ❑

If yes, please explain _____

_____

Significant past and current medical problems: _____

_____

Past surgeries and dates: _____

_____

_____

List all medications (including birth control and over-the-counter medications you routinely take): _____

_____

Medication Allergies: _____

_____

Over

Patient History Form cont.

Are you allergic to: Iodine ❑ Adhesive Tape ❑ Latex ❑ Merthiolate ❑ Plastic Bandages ❑

Social History

Have you smoked cigarettes? Yes ❑ No ❑ How many packs per day? _____

How many years? _____

Do you currently smoke cigarettes? Yes ❑ No ❑ How many packs per day? _____

How many years? _____

Have you chewed tobacco? Yes ❑ No ❑ How many cans a day? _____

How many years? _____

Do you currently chew tobacco? Yes ❑ No ❑ How many cans a day? _____

How many years? _____

Do you drink alcoholic beverages? Yes ❑ No ❑ Average drinks per week _____

Have you used "street" drugs? Yes ❑ No ❑ How many years? _____ Type _____

Have you ever taken steroids? Yes ❑ No ❑ When? _____

Occupation or retired occupation: _____

Exercise history/sports: _____

Family history: Medical problems of parents, brothers, sisters, and/or children such as cancer, heart disease, arthritis, high blood pressure, diabetes, etc: _____

_____

_____

Are you pregnant? Yes ❑ No ❑

Are you trying to get pregnant? Yes ❑ No ❑

REVIEW OF SYSTEMS

Check any problems you currently experience or have in the past

Head & Neck
- ❑ Nose Bleeds
- ❑ Pain and tingling with neck motion
- ❑ Neck lumps or swelling
- ❑ Visual difficulties
- ❑ N/A

Respiratory
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Coughing blood
- ❑ N/A

Heart & Blood Vessel
- ❑ Chest pain
- ❑ Pounding of the heart
- ❑ Congestive heart failure
- ❑ Fainting or blackouts
- ❑ Foot or ankle swelling
- ❑ Blood clots
- ❑ High blood pressure
- ❑ Heart murmur
- ❑ Phlebitis
- ❑ Anemia
- ❑ Blood transfusions
- ❑ N/A

Musculoskeletal/Neuro
- ❑ Arthritis
- ❑ Muscle or nerve disorder
- ❑ Numbness or tingling
- ❑ Strokes
- ❑ Fractures:
  (Which bones and when):

  _____

  _____

  _____
- ❑ N/A

Psychological
- ❑ Depression
- ❑ Anxiety
- ❑ Chemical dependency
- ❑ Seizures
- ❑ N/A

Skin Problems
- ❑ Bruise Easily
- ❑ Open sores
- ❑ N/A

Digestive
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Liver problems
- ❑ Bowel movement abnormalities
- ❑ Rectal bleeding
- ❑ Ulcers
- ❑ Heartburn
- ❑ N/A

Urinary & Reproductive
- ❑ Burning with urination
- ❑ Urinating more than 5-6 times daily
- ❑ Blood in urine
- ❑ Trouble with urine flow
- ❑ Prostate problems
- ❑ Unusual vaginal bleeding
- ❑ N/A

Endocrine
- ❑ Diabetes
- ❑ Thyroid
- ❑ Weight change recently
- ❑ N/A

Anesthesia
- ❑ Anesthesiologist had difficulties inserting a breathing tube
- ❑ You or family members had high fever or complications with anesthesia
- ❑ Nausea or vomiting after surgery
- ❑ N/A

Type of Anesthesia that caused reaction

_____

Which surgery?

_____

When?

_____

Reactions:

_____

_____

_____

- ❑ N/A