HEIDEN ORTHOPAEDICS

PATIENT HISTORY SHEET

Name:____ Today's Date: ____________________

Occupation:__________________________________ Age: ________ Height: ________ Weight: ________

Refrerring Physician:_________________________ Date of birth: ____________________

*Date of Injury or onset of symptoms?______________________

*Are you still working in spite of your illness/injury?______________________

*Which body part is involved? ______________________

*List activities which cause pain:______________________

*Rate the pain (Please circle: 0 = no pain; 10 = most severe)
0 1 2 3 4 5 6 7 8 9 10

*What activities/medications help your condition?______________________

____

*What previous treatment have you had for this problem?______________________

____

*Are you right or left hand dominant?______________________

I have reviewed this patient's medical history sheet as they have recorded it.

Signed:

____
Provider's Signature

____
Date

MEDICAL HISTORY: - Please check any of the following that you have had:

__ Diabeties: type 1 or 2
__ Thyroid Problems
__ Heart Problems
__ Blood Clots
__ High Blood Pressure
__ Stroke
__ Seizures

__ Asthma Problems
__ Tuberculosis (TB)
__ Liver Problems
__ Elevated Cholesterol
__ Kidney, Bladder or Prostate Problems
__ Stomach Ulcer or Reflux Problems
__ Difficulty Opening Mouth

__ Muscle Disorders
__ Mental Health Disorders
__ Skin Disorders
__ Sleep Apnea
__ Severe/Migraine Headaches
__ Arthritis
__ Cancer - Type/Location ____
____

* Other serious health conditions: ____

____

ALLERGIES:

Are you allergic to latex? YES NO

Are you allergic to any medications? YES NO

If YES, please list: ____

Please list any other allergies you may have: ______________________________

SURGICAL HISTORY: - Please list any previous surgeries you have had:

SURGERY	DATE	PHYSICIAN	HOSPITAL	CITY/STATE

CURRENT MEDICATIONS: - Please list all medications you are currently taking:

MEDICATION	DOSAGE (mg, mcg, etc.)	FREQUENCY (times per day, as needed, etc.)

REVIEW OF SYSTEMS:

MUSCULOSKELETAL:

Do you have any chronic or intermittent back pain?	YES	NO
Do you have problems with any other joints such as pain, swelling, stiffness or weakness?	YES	NO
If YES, please explain: ____________		

SKIN:

Do you have any rashes, lesions, lumps or sores?	YES	NO
If YES, please explain: ____________		

NEUROLOGICAL:

Do you have any problems with seizures or other nervous disorders that require medication?	YES	NO
If YES, please explain: ____________		
Do you have any previous history of stroke?	YES	NO
Do you have any problems with headaches or dizziness?	YES	NO

PSYCHIATRIC:

Do you have a drug or alcohol addiction?	YES	NO
Do you have any problems with depression?	YES	NO

ENDOCRINE:

Do you have any problems with excessive thirst or intolerance to heat or cold?	YES	NO

HEMATOLOGY:

Do you have any problems with easy bleeding?	YES	NO
Do you have any problems with easy bruising?	YES	NO
Do you have any problems with anemia?	YES	NO
Have you ever had a blood clot?	YES	NO

CONSTITUTIONAL:

Have you had any recent coughs or colds?	YES	NO

EYES:

Do you have any tearing, eye pain, pressure or change in vision?	YES	NO
If YES, please explain:		

EAR, NOSE, & THROAT:

Do you have any sore throats?	YES	NO
Do you have difficulty hearing?	YES	NO

CARDIOVASCULAR:

Do you have any chest or arm pain on exertion?	YES	NO
Do you have chronic cough either dry or with blood or sputum?	YES	NO

GASTROINTESTINAL:

Do you have gastritis?	YES	NO
Do you have colitis?	YES	NO
Do you have diverticulitis?	YES	NO
Do you have hepatitis?	YES	NO

GENITOURINARY:

Do you have prostate trouble?	YES	NO
Do you have to get up at night to urinate?	YES	NO
Do you have frequency of urination?	YES	NO

FAMILY HISTORY:

Has or does anyone in your family have any of the following?

Heart Trouble	YES	NO	Relationship: ____________
Diabetes	YES	NO	Relationship: ____________
Tuberculosis	YES	NO	Relationship: ____________
High Blood Pressure	YES	NO	Relationship: ____________
Pneumonia	YES	NO	Relationship: ____________
Cancer	YES	NO	Relationship: ____________
Sudden Death	YES	NO	Relationship & Cause: ____________

SOCIAL HISTORY:

Do you use tobacco?	YES	NO	Form of tobacco: ____________
Frequency of daily use (eg., 2 packs per day) ____________			
Do you drink alcoholic beverages?	YES	NO	Average # of drinks per week: ____________
Do you have a history of substance abuse?	YES	NO	

OTHER CONSIDERATIONS:

Do you have vision or hearing disabilities?	YES	NO	Please specify: ____________
Do you have any physical limitations?	YES	NO	Please specify: ____________
Is there anything else we should know about you? ____________			

PATIENT SIGNATURE: ____________ **DATE:** ____________