Carolina Orthopedics& Sports Medicine

Patient / History

Patient Name:____Date:________________

Occupation:____

Primary Physician:______________________________Referred By: ______________________

Age:____________Date of Birth:____________________

Sitting BP:____________Weight:________Height:_________Heart Rate: ________Resp. Rate:______Temp.______

HISTORY
CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

1. **What are we seeing you for?(**Description of Problem**), Include where pain/problem is located and how long it has been present**
____
____
____
____

2. How severe is the pain / problem on a scale of 1 to 10?______ Does the pain/problem occur at a specific time?__________
3. What makes the pain / problem worse or better?____
4. How did this accident / injury occur?____

Patient **MEDICAL** History
(Circle the correct answer)

Condition		
Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis / Gout	No	Yes
Convulsions	No	Yes
Bleeding Tendency	No	Yes
Acute Infections	No	Yes
Hereditary Defects	No	Yes

FAMILY Medical History
(Circle the correct answer)

Condition		
Diabetes	No	Yes
Hypertension	No	Yes

OTHER Family Medical History
____
____
____

Patient **SOCIAL** History
(Circle the correct answer)

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously, but quit		Current packs/day______	
Use of Drugs:	Never	Type, frequency____________________			

Previous Hospitalizations / Surgeries / Serious Injuries? When?
____ _____
____ _____
____ _____
____ _____

Other Medical Problems:____
____

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PHARMACY: ____

CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

ENT

Hearing loss or ringing	No	Yes
Nose bleeds	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

INTEGUMENTARY (Skin)

Rash or itching	No	Yes
Change in skin color	No	Yes
Varicose veins	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensation	No	Yes

PSYCIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

ALLERGIES: HISTORY OR REACTION TO MEDICINES OR OTHER AGENTS

Penicillin	No	Yes
Other antibiotics - List: ______________________		
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin	No	Yes
Iodine, methiolate or other antiseptic	No	Yes
Tetanus antitoxin or other serums	No	Yes
Other drugs / medications - List__________________________		

ADDITIONAL COMMENTS

____

____

____