CAROLINA ORTHOPEDICS
SPORTS MEDICINE & PHYSICAL THERAPY

Patient History

Date: ______________

Patient Name: ______________________________ Date of Birth: ______________

Occupation: ______________________________

Primary Physician: ______________________ Referred By: ______________________

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

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2. How long does the pain / problem last? ______________

3. How severe is the pain / problem on a scale of 1 to 10? ________

4. What is the frequency of the pain / problem? ______________

5. Is the pain / problem relieved by anything? ________

6. If accident / injury when did it occur? ______________

7. Are you pregnant? ______________

MEDICAL HISTORY

Do You or a Family Member Have Any History of the Following?

Yourself		Family Member (Mother, Father, Brother, Sister)
Yes No	**Cancer (type)**______________	Yes No
Yes No	**CVA / Stroke**	Yes No
Yes No	**Congestive Heart Failure**	Yes No
Yes No	**COPD**	Yes No
Yes No	**Coronary Artery / Heart Disease**	Yes No
Yes No	**Diabetes**	Yes No
Yes No	**DVT**	Yes No

Yourself		Family Member (Mother, Father, Brother, Sister)
Yes No	**Hypertension / Blood Pressure**	Yes No
Yes No	**Peptic Ulcer Disease**	Yes No
Yes No	**Rheumatoid Arthritis**	Yes No
Yes No	**Scoliosis**	Yes No
Yes No	**Other:**______________________	Yes No
Yes No	**Other:**______________________	Yes No
Yes No	**Other:**______________________	Yes No

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously (Quit) Current Packs per Day__

Use of Illicit Drugs: Never Type, Frequency__________________

Allergies

Medications: (ex. antibiotics, aspirin) ______________________________

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Environmental: (ex. shellfish, bee stings) ______________________________

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Previous Hospitalizations / Surgeries / Serious Injuries?

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Medications You Currently Take

Name	Dose	How Often

Name	Dose	How Often

What Pharmacy Do You Use: ______________________________

Review of Systems

Check All That Apply

Constitutional

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Not Feeling Well
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other____________________

Eyes / Ear / Nose / Throat

- ☐ Blurred Vision
- ☐ Difficulty Swallowing
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Ringing in Ears
- ☐ Dizziness
- ☐ Vision Loss
- ☐ Other____________________

Lungs

- ☐ Chest Pain
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Recent Infections
- ☐ Known TB Exposure
- ☐ Wheezing
- ☐ Other____________________

Heart / Arteries / Veins

- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Leg Swelling
- ☐ Fainting
- ☐ Irregular heartbeat
- ☐ Other____________________

Stomach / Bowels

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Black Tarry Stools
- ☐ Diarrhea
- ☐ Heartburn / Reflux
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Other____________________

Kidneys / Bladder

- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Lose Bladder Control
- ☐ Other____________________

Metabolic

- ☐ Cold Intolerant
- ☐ Heat Intolerant
- ☐ Other____________________

Brain / Spinal Cord / Nerves

- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Poor Coordination
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Numbness / Tingling
- ☐ Seizures
- ☐ Other____________________

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Disorder
- ☐ Other____________________

Skin

- ☐ Contact Allergy
- ☐ Rash
- ☐ Skin Infection
- ☐ Other____________________

Blood

- ☐ Bleeding
- ☐ Bruising
- ☐ Other____________________

Immunological

- ☐ Asthma
- ☐ Bee Sting Allergies
- ☐ Rash / Skin Inflammation
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Other____________________

Additional Comments: ____

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I agree that this information is correct to the best of my knowledge: Signature______________________________ Date__________

History Updated: Date__________ History Updated: Date__________ History Updated: Date__________