

DATE: _____
MD you are seeing today

HIGHLAND CENTER FOR
ORTHOPAEDICS & SPORTS MEDICINE

PCP/REFERRING MD

PATIENT HISTORY FORM

Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Past Medical History:

Do you have?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabete | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other _____ | |

Ortho Surgery

- Bone or Joint
Type: _____

Past Surgical History:

Have you had?

- Thyroid
 Appendectomy
 Hysterectomy
 Wisdom Teeth
 Gallbladder
 Tonsillectomy
 Other _____
 None

***** Allergies:** NONE or list each allergy _____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)* None

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

Social History:

- Occupation: _____
Dominant Hand: R L
 Tobacco Use Yes No
 Alcohol Use Yes No
Height _____ Weight _____

Review of Systems: *Do you have?*

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Skin Lesion | <input type="checkbox"/> Seizures | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression | <input type="checkbox"/> |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Reflux | <input type="checkbox"/> Bruising | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Cough | |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shortness of Breath | |