

Orthopaedic Sports Specialists of Louisiana

Confidential Patient Medical History

Patient Hx 12/20/07

FOR OFFICE USE ONLY: DR. HIGGINS _____ DR. ELIAS _____
Height: ____' ____" Weight: _____ lbs. Age: _____ BP _____ Pulse _____ Temp _____

Patient Name: _____ Date of Birth: _____ Gender: M / F

Primary Phone #: _____ Cellular Phone # _____ Work Phone # _____

Date of Injury: _____ Are you: Right-handed / Left-handed

Occupation: _____ Primary Care Physician: _____

Were you sent to our office by a physician? Yes / No If so, please provide:

Requesting Physician's Name: _____ Phone # _____

History of Present Illness

Why are you here today? _____

Is this work related? Yes / No Any lawsuits pending regarding this injury/illness? Yes / No

Location: _____ Quality: _____
Where is the pain/problem? Does it travel to other areas? Is the pain dull, throbbing, sharp? If lump, is it warm, tender, red?

Severity: _____ Duration: _____
How severe is the pain on a scale from 1-5 with 5 being the most severe? How long have you had this pain/problem? When did it start?

Timing: _____ Context: _____
Does the pain/problem occur at a specific time? Is it rare, intermittent, or constant? What were you doing at the onset of this pain/problem?

Modifying factors: _____
What makes this problem worse or better? (activities)

Have you seen any other physicians regarding *this* condition prior to coming to our office? Yes / No

<u>Doctor</u>	<u>When</u>	<u>Tests</u>	<u>Results</u>	<u>Treatment</u>
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Past History of Present Illness

Have you ever experienced any injury or symptoms regarding this body part? Yes / No *If so, provide details:*

Please list any hobbies/sports you enjoy: _____

Which of the above activities are you unable to perform due to your pain? _____

Past Medical History: Have you ever had any of the following? *Circle all that apply.*

ADD	Bladder Infections	DVT (blood clot)	High Blood Pressure	Mitral Valve Prolapse	Sickle Cell
AIDS or HIV+	Bleeding Tendency	Epilepsy	High Cholesterol	Pneumonia	Sleep Apnea
Anemia	Blood Transfusions	Fibromyalgia	Infectious Mono	Polio	Stroke
Arthritis - Osteo	Bronchitis	Glaucoma	Kidney Disease	Restless Leg Syndrome	Thyroid Disease
Arthritis - Rheumatoid	Cancer	Gout	Low Blood Pressure	Rheumatic Fever	Tuberculosis
Asthma	Depression/Anxiety	Heart Disease	Lupis	Scarlet Fever	Ulcers
Back Trouble	Diabetes	Hepatitis	Migraine Headaches	Seizures	

Other: _____

Past Surgical/Hospitalization History:

<u>Date</u>	<u>Surgery/Illness</u>	<u>Doctor</u>	<u>Hospital, City, State</u>
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Medications: Include non-prescription & Herbal Supplements

Drug name	Dosage	Frequency

Allergies:

Medication	Reaction

Tape Allergy: Yes / No Latex Allergy: Yes / No

Patient Social History:

<u>Marital Status</u>	<u>Use of Alcohol</u>	<u>Use of Tobacco</u>	<u>Living Situation</u>	<u>Use of Recreational Drugs</u>
Single	Never	Never	With Family	No
Married	Rarely	Previously, but quit	With Friends	Yes – please list which
Divorced	Moderate	Current:	Alone	_____
Widowed	Daily	_____ Use per day	Other	_____

Family Medical History:

<u>Age</u>	<u>Conditions or Diseases</u>	<u>If Deceased, Cause of Death</u>
Father: _____	_____	_____
Mother: _____	_____	_____
Siblings: _____	_____	_____
_____	_____	_____

Review of Systems: Please indicate any personal history below – circle all that apply.

Musculoskeletal Joint Pain Joint stiffness or swelling Weakness of muscles or joints Muscle pain or cramps Back pain Cold extremities Difficulty in walking	Cardiovascular Heart trouble Chest pain or angina pectoris Palpitation Shortness of breath while walking Swelling of feet, ankles, or hands	Endocrine Excessive thirst or urination Heat or cold intolerance Skin becoming dryer	Gastrointestinal Loss of appetite Nausea or vomiting Frequent diarrhea Constipation Rectal bleeding, blood in stool Abdominal pain
Constitutional Symptoms Bad general health lately Recent weight change Fever Fatigue Headaches	Genitourinary Frequent urination Burning or painful urination Blood in urine Incontinence or dribbling	Hematologic/Lymphatic Slow to heal after cuts Bleeding or bruising tendency Anemia Enlarged glands	Allergic/Immunologic List food/environmental allergies _____ _____ _____
Ears/Nose/Mouth/Throat Hearing loss or ringing Earaches or drainage Chronic sinus problems Nose bleeds Bleeding gums Sore throat or voice change Swollen glands in neck	Integumentary (skin, breast) Rash or itching Changes in skin color Varicose veins	Psychiatric Memory loss or confusion Nervousness Depression Insomnia	Other: Information your doctor might need: _____ _____ _____
	Neurological Light headed or dizzy Numbness or tingling sensations Tremors Paralysis	Respiratory Chronic or frequent coughs Spitting up blood Shortness of breath Wheezing	

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information may be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of Patient or Parent of Minor _____ Date _____

Signature of Physician _____ Date _____