

Orthopaedic Sports Specialists of Louisiana

Confidential Patient Medical History

Patient Hx 05/25/10

FOR OFFICE USE ONLY: DR. ELIAS DR. ELLENDER DR. HIGGINS DR. HILLDENBRAND
Height: ___' ___" Weight: ___ lbs. Age: ___ BP ___ Pulse ___ Temp ___

Patient Name: _____ DOB: _____ Gender: M / F
Primary Phone #: _____ Cellular Phone # _____ Work Phone # _____
Date of Injury: _____ Are you: Right-handed / Left-handed
Occupation: _____ Primary Care Physician: _____
Referring Physician: _____

History of Present Illness

Why are you here today? _____ Side affected _____

Is this condition related to: Work injury? Yes No If yes, Verification of Work Injury Required
Auto injury? Yes No If yes, name of liable party: _____
Student athlete injury? Yes No If yes, Student Athletic Injury Form Required

Pain and Discomfort

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 1-10 with 10 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>

Past History of Present Illness

Have you ever experienced any injury or symptoms regarding this body part before? Yes / No *If yes, 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>

Current Medications & Supplements:

Drug name	Dosage	Frequency

Allergies:

Medication Allergies	Reaction

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

Patient Social History:

Marital Status:	Single	Married	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily
Use of Tobacco:	Never	Previous, but quit	Current Use Per Day: _____	
Living Situation:	With Family	With Friends	Live Alone	Other _____
Use of Recreational Drugs:	Never	Previous	Current	_____

Family Medical History:

Age	Known Conditions or Diseases	If Deceased, Cause of Death
Father: _____	_____	_____
Mother: _____	_____	_____
Siblings: _____	_____	_____
_____	_____	_____

Review of Systems: Please indicate if you have had any of the following circle all that apply.

<p><u>Musculoskeletal</u> Joint Pain Joint stiffness or swelling Weakness of muscles or joints Muscle pain or cramps Back pain Cold extremities Difficulty in walking</p> <p><u>Constitutional Symptoms</u> Bad general health lately Recent weight change Fever Fatigue Headaches</p> <p><u>Ears/Nose/Mouth/Throat</u> Hearing loss or ringing Earaches or drainage Chronic sinus problems Nose bleeds Bleeding gums Sore throat or voice change Swollen glands in neck</p>	<p><u>Cardiovascular</u> Heart trouble Chest pain or angina pectoris Palpitation Shortness of breath while walking Swelling of feet, ankles, or hands</p> <p><u>Genitourinary</u> Frequent urination Burning or painful urination Blood in urine Incontinence or dribbling</p> <p><u>Integumentary (skin, breast)</u> Rash or itching Changes in skin color Varicose veins</p> <p><u>Neurological</u> Light headed or dizzy Numbness or tingling sensations Tremors Paralysis</p>	<p><u>Endocrine</u> Excessive thirst or urination Heat or cold intolerance Skin becoming dryer</p> <p><u>Hematologic/Lymphatic</u> Slow to heal after cuts Bleeding or bruising tendency Anemia Enlarged glands</p> <p><u>Psychiatric</u> Memory loss or confusion Nervousness Depression Insomnia</p> <p><u>Respiratory</u> Chronic or frequent coughs Spitting up blood Shortness of breath Wheezing</p>	<p><u>Gastrointestinal</u> Loss of appetite Nausea or vomiting Frequent diarrhea Constipation Rectal bleeding, blood in stool Abdominal pain</p> <p><u>Allergic/Immunologic</u> List food/environmental allergies _____ _____ _____</p> <p><u>Other:</u> Information your doctor might need: _____ _____ _____</p>
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To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information or omitting information may be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status with each and every visit. 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