

# Orthopaedic Sports Specialists of Louisiana

## Confidential Patient Medical History

Updated 1/09/12

**FOR OFFICE USE ONLY: DR. ELIAS DR. ELLENDER DR. HIGGINS DR. HILDENBRAND**  
**Height:** \_\_\_\_\_' \_\_\_\_\_" **Weight:** \_\_\_\_\_ lbs. **Age:** \_\_\_\_\_ **BP** \_\_\_\_\_ / \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Temp** \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Reason for present visit? \_\_\_\_\_ Affected Side: Left Right Bilateral

Date of Injury: \_\_\_\_\_ Are you: Right-handed ? / Left-handed?

Occupation: \_\_\_\_\_ Are you currently pregnant? Yes / No

**Is this visit related to:** Work injury? Yes No Verification of Work Injury Required from employer.  
Student athlete injury? Yes No Student Athletic Injury Form Required from school.  
Auto injury? Yes No Name of liable party: \_\_\_\_\_

### Pain & Discomfort:

**Location:** \_\_\_\_\_ **Type:** \_\_\_\_\_  
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)

### Past History of Present Illness:

Were you referred here by another doctor or therapist for this condition? Yes / No Referred By \_\_\_\_\_

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>

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

List hobbies/activities 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>Facility</u>

**Current Medications & Supplements:**

Drug name:	Dosage (mg):	How often do you take?	Date Began Taking:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Preferred Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Allergies:**

Medication Allergies: \_\_\_\_\_ Describe Reaction: \_\_\_\_\_

Food Allergies: \_\_\_\_\_ Environmental Allergies: \_\_\_\_\_  
Surgical Tape Allergy? Yes / No Latex Allergy? Yes / No

**Patient Social History:**

<b>Tobacco Use:</b>	Never	Former	Occasional Use	Daily Use _____ (amount)
<b>Alcohol Use:</b>	None Past Year	1 per day	2-3 per day	4-5 per day 6+ per day
<b>Use of Recreational Drugs:</b>	Never	Previous	Current _____ (list)	
<b>Living Situation:</b>	With Family	With Friends	Live Alone	Nursing Home Other _____

**Family Medical History:**

Known Conditions or Diseases of Immediate Family: \_\_\_\_\_ If Deceased, Cause of Death: \_\_\_\_\_

Father: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Siblings: \_\_\_\_\_

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

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

Patient verifies that questions on this form have been answered accurately. Patient understands that incorrect information or omissions may be dangerous to his health. It is patient responsibility to inform the doctor of any changes in my medical status, prescriptions & insurance information with each and every visit. Patient authorizes the health care staff to perform medical testing & treatment.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewing Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_