

New West Sports Medicine & Orthopaedic Surgery, P.C. - Health History

Patient Name: _____ Left Handed Right Handed Date: _____

DOB: _____ Age: _____ Male/Female Height: _____ Weight: _____

Occupation:

History of Present Illness

Reason for visit: Right Left Bilateral Was this the result of a work or auto injury?
 ankle arm back clavicle elbow Yes No Date of injury? _____
 foot hand hip knee leg neck How and when did the problem start?
 pelvis rib shoulder wrist other _____

Pain Scale (circle one number) No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

For this related problem have any tests been done?

X-rays _____ CT Scan _____ MRI _____ EMG _____ Other _____

If so, where and when? _____

Have any treatments been done for this problem? _____

Past Medical History (please check all that apply)

| | | | |
|---------------------------------|----------------|--------------------------------------|----------------|
| Angina, heart failure or attack | Yes ___ No ___ | Arthritis | Yes ___ No ___ |
| Heart Valve Problem | Yes ___ No ___ | Osteoporosis | Yes ___ No ___ |
| High Blood Pressure | Yes ___ No ___ | Thyroid Disorders | Yes ___ No ___ |
| Irregular Heartbeat | Yes ___ No ___ | Ulcers/Stomach Bleeding/Indigestion | Yes ___ No ___ |
| Anemia | Yes ___ No ___ | Kidney/Bladder Infections | Yes ___ No ___ |
| Blood Transfusion | Yes ___ No ___ | Difficulty Voiding | Yes ___ No ___ |
| Bleeding Disorder | Yes ___ No ___ | Psoriasis/Skin Rash | Yes ___ No ___ |
| Blood Clots/Phlebitis | Yes ___ No ___ | Visual Loss or Glaucoma | Yes ___ No ___ |
| Asthma/Shortness of Breath | Yes ___ No ___ | Hearing Loss | Yes ___ No ___ |
| Emphysema/Chronic Bronchitis | Yes ___ No ___ | Night Sweats, Weight Gain/Loss | Yes ___ No ___ |
| Pneumonia | Yes ___ No ___ | Depression or Anxiety | Yes ___ No ___ |
| Hepatitis, Jaundice or HIV | Yes ___ No ___ | Chemical Dependency/Alcoholism | Yes ___ No ___ |
| Tuberculosis | Yes ___ No ___ | Sleep Apnea | Yes ___ No ___ |
| Cancer | Yes ___ No ___ | Reaction to General/Local Anesthesia | Yes ___ No ___ |
| Diabetes | Yes ___ No ___ | Have you had Cortisone? | Yes ___ No ___ |
| Seizures/Stroke | Yes ___ No ___ | Other: _____ | |

User of

Tobacco Yes Pks/day: _____ No Alcohol Yes Frequency: _____ No Street Drug Yes No

Family History

Cancer Goiter Kidney Disease
 Bleeding Tendency Heart Disease Stroke
 Diabetes High Blood Pressure Other _____

Have you or anyone in your family (mother, father, sister, brother) ever had a reaction to anesthetic, general or local, causing high fever (malignant hyperthermia), blood pressure problems, hepatitis or any other types of allergic reaction? Yes _____ No _____ If yes, please explain: _____

Signature: _____ Physician Signature: _____ Date: _____

Patient Information

Patient Name: _____ DOB: _____

Pharmacy: _____ Pharmacy Phone #: _____

Date of Last Tetanus Shot: _____ Are you allergic to latex? Yes No

Allergies: (Please list)

Medications: (Please list all prescription, non-prescription, birth control, and herbals)

| Generic/Brand Name of Prescription | Dosage (mg) | Generic/Brand Name of Prescription | Dosage (mg) |
|------------------------------------|-------------|------------------------------------|-------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Surgeries: (Please list all past surgeries and dates if known)

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

OFFICE USE ONLY: Medications verified

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