SSMHealth
Orthopedics

PATIENT HISTORY FORM *BP:_____ PULSE_____ *

Primary Physician_____**Referring physician:**_____(FIRST/LAST NAME) *FOR OFFICE USE ONLY*

What is your pain scale 0-10? (10 being severe) _____

Name: _____ **DOB:**_____ **Age:**_____ **Height:** _____ **Weight:** _____

Date of Injury/when symptoms began? _____ **Body part affected** _____ **left/right (circle)**

Is this work related? _____ **If yes, have you filed a worker's compensation claim?** ☐**Yes** ☐ **No**

What activity were you performing at the time your symptoms began? _____

What, if anything, makes your symptoms better? _____

What, if anything, makes your symptoms worse? _____

Do any of the below describe your problem? (PLEASE CHECK)

☐**Coughing or sneezing increases the symptoms.**
☐**I have fever.**
☐**I have suffered from a loss of bowel or bladder control.**
☐**I have numbness and tingling.**
☐**I have missed work because of this problem.**
☐**I have weight loss.**
☐**I have night sweats.**
☐**I have pain that awakens me.**
☐**I have weakness.**
☐**I have a history of cancer.**

Have you been treated by another physician, chiropractor, or therapist for this condition? (If yes, please explain)

_____

Have you had any of the following exams in regards to this injury?

	Circle Yes or No		when/where		Circle Yes or No		when/where
Xray	**Yes**	**No**	_____	**Arthrogram**	**Yes**	**No**	_____
MRI	**Yes**	**No**	_____	**Myelogram**	**Yes**	**No**	_____
CT	**Yes**	**No**	_____	**EMG**	**Yes**	**No**	_____

Check any medical conditions you or your immediate family have now or have had in the past.

	Self	Family		Self	Family		Self	Family
High blood pressure	☐	☐	Heart Disease	☐	☐	Depression	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐	Gastric Ulcers	☐	☐
Hyper/Hypothyroid	☐	☐	Hepatitis/Liver dz	☐	☐	Arthritis	☐	☐
Asthma/emphysema	☐	☐	Peripheral Vascular dz	☐	☐	Cancer	☐	☐
Seizure	☐	☐	Blood clots	☐	☐	**Specify type of cancer** _____		

List any previous surgeries/hospitalizations: _____

_____

List current medications (or attach list): _____

_____

List allergies and drug reactions: _____

Occupation: _____ **Living arrangements:** (i.e. alone, with child, etc) _____

Do you smoke? (Circle one) Yes No How many packs per day? _____ How many years? _____

Do you consume alcohol? (Circle one) Yes No How many drinks per week? _____

Do you use recreational drugs? (Circle one) Yes No Type of drug(s): _____

REVIEW OF SYSTEMS: Please check if you have experienced or are experiencing any of the following:

☐Constant Fatigue
☐Weight Loss
☐Weight Gain
☐Fever
☐Chill
☐Frequent Headaches
☐Rashes
☐Nail changes
☐Dizziness
☐Chest Pain
☐Swollen Glands
☐Ringing in the ears
☐Chronic cough(s)
☐Recurrent Nose bleeds
☐Bruising
☐Shortness of breath with exertion
☐Anxiety
☐Vomiting
☐Nausea
☐Blood in Stool
☐Frequent diarrhea
☐Incontinence
☐Urinary frequency
☐Seizure
☐Muscle cramps
☐Tremors
☐Night sweats
☐Sleep disturbance
☐Depression

Patient Signature _____ **Date**_____ **Physician Initial**____