WEST END ORTHOPAEDIC CLINIC

PATIENT HISTORY

Patient Name: _____ Height: _____ Weight: _____ Today's Date: _____

Social Security #: _____ Age: _____ Date of Birth: _____

Name of Primary Care/Family Physician: _____

Emergency Contact: _____ Phone #: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

_____

_____

_____

_____

Have you been treated for this problem? ( ) No ( ) Yes

Date of injury / Onset of problem: _____

Current problem is the result of a(n): CHECK all that apply

☐ Car Accident ☐ Work Accident ☐ Other Accident State accident occurred in: _____

PAST MEDICAL HISTORY *(are you currently receiving treatment or have you received treatment in the past for any of the following conditions?)*

Yes	No		Yes	No		Yes	No		Yes	No	
____	____	Anemia	____	____	Diabetes	____	____	Low Blood Pressure	____	____	Sexually Trans-
____	____	Arthritis	____	____	Epilepsy	____	____	Lung Problems			mitted Disease
____	____	Asthma	____	____	Heart Disease	____	____	Phelbitis/Blood Clots	____	____	Stroke
____	____	Birth Defects	____	____	Hepatitis	____	____	Polio	____	____	TB
____	____	Bladder Problems	____	____	HIV	____	____	Psychological	____	____	Thyroid Diease
____	____	Bleeding Disorder	____	____	High Blood Pressure	____	____	Recurrent Infection	____	____	Ulcer
____	____	Bowel Problem(s)	____	____	Kidney Disease	____	____	Rheumatic Fever	____	____	Currently Pregnant
____	____	Cancer	____	____	Intestinal Disorder	____	____	Scarlet Fever			

Please specify any other medical problems: _____

_____

_____

_____

DRUG ALLERGIES: *Please describe any drug symptom(s) you have, listing your common reaction and treatment for this problem*

Allergy To (drug name)	Reaction (itching, cough, hives, etc)	How is/was reaction treated:

( ) I do NOT have any known drug allergies

SURGICAL HISTORY:

Surgery/Hospitalizations	Year	Any complications

Have you ever had any problem with anesthesia? ( ) No ( ) Yes - describe: _____

Reviewed by _____

Over please

FAMILY HISTORY: *(Have mother, father, grandparents, brothers or sisters been treated in the past or are currently receiving treatment for any of the following conditions?)*

____ Cancer ____ Diabetes ____ Heart Disease ____ Tuberculosis ____ Kidney Disease Arthritis
____ None of these ____ Other (specify)

PLEASE LIST HEALTH STATUS OR CAUSE OF DEATH FOR THE FOLLOWING FAMILY MEMBERS:

Mother: _____ Father: _____

SOCIAL HISTORY

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

( ) Employed - occupation _____ ( ) Work in home ( ) Student ( ) Retired

Children? ( ) No ( ) Yes - #_____ Do you live alone? ( ) No ( ) Yes

Smoking currently? ( ) No ( ) Yes ____ # packs per day for_____ years.

Do you consume alcohol products? ( ) No ( ) Yes if yes, amount and frequency _____

REVIEW OF SYSTEMS: *Please mark the following symptoms you have experienced on a regular basis*

GENERAL
- ____ fever
- ____ night sweats
- ____ weight gain
- ____ weight loss

EYES
- ____ blurring
- ____ eyestrain
- ____ glasses/contacts
- ____ discharge

THROAT
- ____ soreness
- ____ hoarsness
- ____ difficulty swallowing

GASTROINTESTINAL
- ____ nausea
- ____ vomiting
- ____ belching
- ____ diarrhea

SKIN
- ____ eruptions/rashes
- ____ cyanosis (bluish tint)
- ____ jaundice (yellow tint)

EARS
- ____ deafness
- ____ ringing in ears
- ____ pain
- ____ discharge

GENITOURINARY
- ____ pain
- ____ frequent urination
- ____ incontinence

NEUROMUSCULAR
- ____ fever
- ____ night sweats
- ____ weight gain
- ____ weight loss

HEAD
- ____ headache
- ____ fainting/blackouts
- ____ trauma

NOSE
- ____ sinusitis
- ____ obstruction

CARDIOVASCULAR
- ____ chest pain
- ____ rapid/throbbing heartbeat
- ____ faintness
- ____ fluid/swelling in extremities

RESPIRATORY
- ____ chest pain
- ____ difficulty breathing
- ____ bloody sputum

Date of last chest x-ray_____

FEMALE REPRODUCTIVE:
Are you or could you be pregnant? ( ) No ( ) Yes

MEDICATIONS: *Please list all medications you take **with or without a prescription** (use additional paper if needed)*

Medication Name	Dosage / # per day	Reason you take this	Any side effects

Patient signature: _____ Date: _____
Reviewed by: _____, M.D. Date: _____
Annual update *(to be completed after one year)*: There are NO CHANGES to the above information in my medical history.

Patient Signature: _____ Date: _____