

PATIENT HISTORY FORM
Orthopedic Associates of Southwest Florida, PA

Date: _____

Right or Left Handed: _____

Name: _____

Date of Birth: _____ Age: _____ Sex: M F Height: _____ Weight: _____ Date of Injury: _____

Reason for which you are seeing the physician today: _____

Have you seen another Physician for this problem? No Yes If Yes, Who? _____

History of Present Illness:

Does anything help or make the problem worse?
Moving around Standing Up Lying on my side

How long does the problem last?
30 minutes 1 hour It is always there

Other: _____

Other: _____

Severity: Minor Moderate Severe

Context: Worsening Recurrent Better

Is the problem constant or variable?
Dull then Sharp Very sharp then leaves Always there

Does the problem interfere with your normal function?
No Yes: _____

Other: _____

Have you missed any work? No Yes: _____

Other Symptoms: Bruising Numbness Tingling Other: _____

Past Medical History: (List any medical problems such as diabetes, high blood pressure, cancer, stroke, gallstones, etc.)

1. _____

3. _____

2. _____

4. _____

Past Surgical History: (List Operations, injuries and hospital admissions)

Date	Operation/Injury	Hospital	Surgeon
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Current Medications: (List all medications, including prescription or over the counter medications such as aspirin, Advil, vitamins, etc.)

Name of Drug	Dosage	Name of Drug	Dosage
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Are you allergic to any medications? NO YES (If yes, please describe)

Name of Drug	Type of Reaction	Name of Drug	Type of Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Social History: Married Single Divorced Separated Child Occupation: _____ Year Retired? _____

Do you have a healthcare surrogate? No Yes: Who _____ Do you have a Living Will? Yes No

Do you share information on your health with your spouse/family? Yes No Date of last physical: _____

Do you smoke? No Yes Cigarettes / Pipe / Cigar? Pack/Day _____ Years _____ Quit? _____ When? _____

Do you drink alcohol? No Yes Beer / Wine / Other? _____ Per Day? _____ How long? _____

Do you drink milk? No Yes Oz. Per day _____ Do you take Calcium Tablets? No Yes Mg? _____

Review of Systems: Please circle **Y**es or **N**o and explain any Yes answers in the space provided.

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other: _____

Eyes

Blurred/double vision Y N
Wear glasses Y N
Pain Y N
Other: _____

Neurological

Stroke Y N
Dizzy spells Y N
Numbness/tingling Y N
Other: _____

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other: _____

Gastrointestinal

Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/heartburn Y N
Other: _____

Cardiovascular

Chest Pain Y N
Varicose Veins Y N
High blood pressure Y N
Other: _____

Hematologic/Lymphatic

Swollen glands Y N
Bleeding tendency Y N
High blood pressure Y N
Other: _____

Integumentary

Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other: _____

Psychologic

Are you lonely/depressed? Y N
Alcohol or Drug dependent? Y N
Considered suicide? Y N
Other: _____

Ear/Nose/Throat/Mouth

Ear Infection Y N
Sore throat Y N
Sinus problems Y N
Other: _____

Genitourinary

Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other: _____

Respiratory

Wheezing Y N
Frequent Cough Y N
Shortness of breath Y N
Other: _____

Musculoskeletal

Broken Bone Y N
Joint Pain/swelling Y N
Neck/Back pain Y N
Bursitis Y N
Gout Y N
Knee Replacement Y N
Hip Replacement Y N
Other: _____

Thank you for taking the time to complete this questionnaire.

Patient/Guardian Signature

Date

PT HX FORM
02/03