Staple

TWIN CITIES ORTHOPEDICS

Robbinsdale Plymouth Maple Grove

PATIENT HEALTH HISTORY

PLEASE COMPLETE PAGE 1 AND 2

Place label here.

Patient Name_____

Birthdate ____/____/____ | Wt_____ Ht_____

Today's Date ____/____/____

Physician you are seeing today _____

Who referred you to our office?_____ Clinic: _____

Is this related to an ❑ auto accident ❑ work injury ❑ other accident? If, injury, date _____/_____/_____

If work injury: Employer _____

Employers Tel. No. _____ W/C Carrier: _____

Part of Body being seen for today_____ Problem began on _____/_____/_____

Describe how pain, injury, or problem occurred, what makes it worse, and what treatment you have had_____

_____

❑ Other M.D. ❑ Physical Therapy ❑ Cortisone Shot ❑ Chiropractic

PAST MEDICAL HISTORY		Do you have a personal history of any of the following: (none or circle)
General	❑ None	Cancer Diabetes Thyroid disease Delayed wound healing Malignant hyperthermia Hepatitis AIDS/HIV Difficulty with anesthesia
Heart/Circulation	❑ None	MI/Heart Attack Blood Clots High Blood Pressure Stroke Abnormal Rhythm Pacemaker Bleeding disorders
Lungs	❑ None	Asthma Emphysema Oxygen dependence Bronchitis
Gastrointestinal	❑ None	Ulcers Appendectomy Gallbladder surgery Crohn's Disease Reflux/GERD
Neuro/Psych	❑ None	Depression Anxiety disorder Schizophrenia Seizures Chemical Dep
Musculoskeletal	❑ None	Arthritis Gout Fracture Ligament injury/Sprain Fibromyalgia Previous Orthopedic Surgery Bone joint infections
Other		**List:**

HOSPITALIZATIONS/SURGERIES	YEAR
List all previous hospitalizations and/or surgeries ❑ None	

MEDICATIONS	
List any medications you are taking and why. Include herbs, inhalers, non-prescription medications ❑ None	
Dosage/ Frequency	**Dosage/ Frequency**

To your knowledge, have you ever taken Prednisone/Cortisone by mouth? ❑ yes ❑ no ❑ don't know

ALLERGIES	
List any medications you are sensitive to and the reaction ❑ None	

Have you ever had a reaction to: ❑ eggs ❑ shellfish/iodine ❑ latex ❑ rubber

Do you use tobacco in any form? ❑ yes ❑ no Quit #____years If yes, # per day____ # of years____

Do you drink alcohol? ❑ yes ❑ no Quit #____years If yes, # per week_____ # of years____

Have you ever used recreational drugs? ❑ yes ❑ no List:_____

Office Use Only: BP_____/_____ P_____ R_____ Sex: M F

☞ Please complete page 2

FAMILY HISTORY (Grandparents, parents, siblings)		
Do you have a family history of any of the following?		❑ **None**
❑ disease of muscles, bones, or nervous system	❑ difficulty with anesthesia	
❑ arthritis ❑ rheumatoid ❑ osteoarthritis	❑ diabetes	
❑ bleeding disorders ❑ blood clots		
If yes, please explain:		

WORK / SOCIAL HISTORY

❑ Married ❑ Single ❑ Widow ❑ Divorced

Children ❑ yes ❑ no How many?_____ Ages_____
Do you live ❑ alone ❑ with family ❑ assisted living ❑ nursing home ❑ other
Are you currently working? ❑ yes ❑ no If no, when did you last work?_____
Occupation: _____ Employer _____ How long?_____

Is your regular work? Heavy Medium Light Sedentary
Are you currently on any work restrictions? ❑ yes ❑ no If yes, what are they?_____

Do you exercise or participate in sports on a regular basis? ❑ yes ❑ no If yes, Please explain:

REVIEW OF SYSTEMS (check No		
General	❑ **None**	Recent unexpected weight loss or gain fatigue fever chills night sweating risk factors HIV/AIDS
Eyes	❑ **None**	double vision blurred vision blind spots glasses/contact lenses glaucoma cataracts legally blind
Ears/Nose/Throat	❑ **None**	ringing in ears difficulty hearing use hearing aids deaf (read lips; ASL) frequent nose bleeds hoarseness dry mouth sinus problems dentures/partial plate/braces/caps
Lungs	❑ **None**	chronic cough wheezing shortness of breath pneumonia coughing blood
Heart/Circulation	❑ **None**	chest pain leg swelling hands/feet always cold leg cramps varicose veins easy bruising
Gastrointestinal	❑ **None**	stomach ulcers problems with bowel movements heartburn nausea swallowing problems
Genitourinary	❑ **None**	incontinence painful urination blood in urine trouble starting stream
Reproductive	❑ **None**	pregnant possible pregnancy menopause prostate problems
Musculoskeletal	❑ **None**	joint pain joint swelling stiffness arthritis gout muscle or tendon injuries fractures childhood deformities or braces
Skin	❑ **None**	rashes lumps sores color changes change in hair or nails skin tears easily difficulty healing skin
Neurological	❑ **None**	numbness or tingling weakness pins and needles tremors/shaking seizures dizziness fainting
Endocrine	❑ **None**	thyroid heat or cold intolerance when others are comfortable excessive thirst excessive sweating
Psychiatric	❑ **None**	depression anxiety excessive stress nervousness panic attacks

Patient Signature:_____ Date_____

Physician Signature:_____ Date_____