

LAKEWOOD ORTHOPAEDICS & SPORTS MEDICINE
PATIENT HISTORY FORM

Please provide us with your insurance and valid ID

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Name _____ DOB: _____ Height: _____ Weight: _____ Date: _____

Age: _____ Sex: M F Marital Status: M S D W Are you Right or Left handed? (circle one)

Street Address: _____ City: _____ State: _____

Zip: _____ SS# _____ Home #: _____ Cell #: _____

Work #: _____ Employer: _____ Occupation: _____

Race: _____ Language: _____ Ethnicity: _____

In case of Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Insurance Holder information if different from above: Name: _____

DOB: _____ SS #: _____ Phone #: _____ Relation: _____

Who is your Primary Care/ Family Doctor? _____

Referred by: _____ Relationship: _____ (Doctor, Coach, Athletic Trainer, Friend, etc.)

School/ Sports Club: _____ Phone#: _____

Are you still working in spite of your illness/injury? YES NO If no, last day worked _____

Did you have an injury to cause your symptoms? Yes NO

If YES, state where it happened (circle one) WORK HOME AUTO SPORTS INJURY

*If this is a sports injury: School Club Recreation

*If school/club, organization name: _____ City: _____

*Do you play on a school team? Yes No Which: _____

*Name of athletic trainer/coach we can contact on you behalf: _____ Phone#: _____

*Date of Accident/Injury? _____ (Onset)

*Which body part is involved? _____ (Location)

CIRCLE ONE: Right Left Both

*How long have you had this pain? _____ (Duration)

*List all activities which cause you pain: _____

*Describe the pain: _____

* Rate the pain (please circle: 0= no pain; 10= most severe)

0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS

CONSTITUTUIONAL:

Have you had had any resent chills?

YES NO

Have you felt fatigue lately?

YES NO

Have you had a fever lately?

YES NO

Do you have night sweats?

YES NO

I have reviewed this patient's
medical history sheet as they
have recorded it.

Provider's Signature

Date

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Patient Name: _____

EYES:

Do you have any tearing, eye pain, pressure or change in vision? YES NO

If yes, please explain: _____

EAR, NOSE & THROAT:

Do you have chronic cough? YES NO

Do you have difficulty hearing? YES NO

CARDIOVASCULAR:

Do you have any chest or arm pain on exertion? YES NO

Do you have irregular heartbeats/ Palpitations? YES NO

GASTROINTESTINAL:

Do you have or have you had any of the following?

Abdominal pain YES NO

Constipation YES NO

Diarrhea YES NO

Nausea YES NO

Vomiting YES NO

GENITOURINARY

Do you have any of the following?

Prostate Trouble? YES NO

Do you have to get up at night to urinate? YES NO

Do you have frequency or urination? YES NO

MUSCULOSKELETAL:

Do you have any chronic or intermittent back pain? YES NO

Do you have any problems with any joints such as pain, Swelling, or weakness? YES NO

If YES, please explain: _____

SKIN:

Do you have any rash, lesions, lumps or sores? YES NO

If YES, please explain: _____

NEUROLOGICAL:

Do you have any problems with numbness? YES NO

Do you have any problems with headaches? YES NO

Do you have any problems with dizziness? YES NO

PSYCHIATRIC:

Do you have any problems with anxiety? YES NO

Do you have any problems with depression? YES NO

Do you have any problems with insomnia? YES NO

ENDOCRINE:

Do you have any problems with excessive thirst or intolerance To heat or cold? YES NO

Do you have any type of glandular problem including diabetes or Thyroid? YES NO

HEMATOLOGY:

Do you have any problems with easy bleeding? YES NO

Do you have any problems with easy bruising? YES NO

Do you have any problems with anemia? YES NO

Have you ever had a blood clot? YES NO

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Patient Name: _____

ALLERGIES:

Are you allergic to any medications?

YES

NO

Iodine Erythromycin Penicillin Sulfa

Latex

Adhesives

Other: _____

Patient Name: _____

PAST MEDICAL HISTORY:

Do you have any of the following?

Heart Trouble YES NO

Diabetes YES NO

High Blood Pressure YES NO

HIV/AIDS YES NO

Rheumatoid Arthritis YES NO

Have you ever had a blood clot?

Cancer YES NO

Asthma/ COPD YES NO

Neck Fusion YES NO

Thyroid Disorder YES NO

Other: _____

YES NO

SURGERIES:

No Previous Surgeries

	<u>Years</u>	<u>Other Surgeries (excluding surgeries listed):</u>	
		<u>Procedure:</u>	<u>Year</u>
Appendix	_____	_____	_____
Gall Bladder	_____	_____	_____
By-Pass/Open Heart (CABG)	_____	_____	_____
Hernia Repair	_____	_____	_____
Tonsils Removed (Tonsillectomy)	_____	_____	_____
Joint Replacement Surgery	_____	_____	_____
Arthroscopic	_____	_____	_____
Hysterectomy	_____	_____	_____
C-Section	_____	_____	_____
Other Bone & Joint Surgeries:	_____	_____	_____

FAMILY HISTORY:

Has or does anyone in your family have any of the following?

Heart Trouble YES NO Relationship: _____

Diabetes YES NO Relationship: _____

Tuberculosis YES NO Relationship: _____

High Blood Pressure YES NO Relationship: _____

Cancer YES NO Relationship: _____

Sudden Death YES NO Relationship & Cause: _____

SOCIAL HISTORY:

Do you live alone? YES NO

Do you have a living will? YES NO

Do you use tobacco? YES NO Form of Tobacco: _____

State frequency of daily use (eg., 2 packs per day): _____

Do you drink alcoholic beverages? YES NO Average # drinks per week: _____

Do you exercise? YES NO

If YES, what type of exercise? _____

Are you on any special diet? YES NO What type: _____

