ORTHOPEDIC CENTER OF TITUSVILLE
PATIENT HISTORY FORM

NAME: **AGE:** **OCCUPATION:**

CIRCLE ONE OR MORE

1. How did the injury occur or pain start?
   a. Suddenly
   b. Gradually
   c. Slip and Fall
   d. Lifting
   e. Injured at work
   f. Auto accident
   g. Sports
   h. No apparent cause
2. When did the injury occur or pain start?
   Date:
3. Did you experience any other injury at this time?
   Yes No If yes, what other injury occured?
4. Frequency of pain
   a. Initially, but not now
   b. Occasionally
   c. All the time

   How bad is the pain?
   a. Mild
   b. Moderate
   c. Marked
   d. Severe
5. What activities make the pain worse?
   a. Exercise/movement
   b. Rest/night
   c. Throwing
   d. Running
   e. Walking
   f. Standing
   g. Bending
   h. Twisting
   I. Sneezing
   j. Lifting
   k. Sitting
   l. After a day's work
6. What makes your pain better?
   a. Rest
   b. Pain pills
   c. Physical therapy
   d. Aspirin
   e. Nothing
   f. Other
7. Does your pain keep you from:
   a. Working
   b. Having fun
   c. Sports
   d. Exercises
   e. No limitations
   f. Other
8. Do you have or have you had:
   a. Buckling
   b. Joint grinding
   c. Joint catching
   d. Locking
   e. Joint Slipping out
   f. Swelling
9. Do you have to stop some/all activities because of your pain? Yes No If yes, how long?
10. Have you been treated prior to the accident/injury for this same kind of problem? Yes No
11. What treatment have you had?
    a. Surgery
    b. Medication
    c. Physical Therapy
    d. Hospitalization
12. Have you had any of these studies done?

a.	MRI?	Yes	No
b.	Arthrogram?	Yes	No
c.	Bone scan?	Yes	No
d.	EMG?	Yes	No
e.	Myelogram?	Yes	No
f.	CT Scan?	Yes	No
g.	X-rays?	Yes	No

SHOW THE DOCTOR WHERE IT HURTS

Please mark the areas on the diagram below where you feel the described sensations on your body. Use the appropriate symbol and include all affected areas.

NUMBNESS - - - - **PINS & NEEDLES o o o o**
BURNING x x x **STABBING / / / /**

FRONT — RIGHT LEFT
BACK — LEFT RIGHT

WORKER'S COMPENSATION/AUTO ACCIDENTS

1. Present Employer: ____________
2. Date of Injury: ____________ Date Last Worked: ____________
3. Current work status: ____________
4. Type of work duties: ____________
5. How long have you worked in this capacity? ____________
6. How did the injury occur? ____________
7. If auto accident, were seatbelts on? Yes No
8. Are you Right Left Handed
9. Have you had any previous work/auto related injuries? Yes No If yes, please list(include dates & body parts).

PLEASE LIST THE THREE(3) MOST IMPORTANT QUESTIONS YOU WOULD LIKE THE DOCTOR TO ANSWER:

MEDICAL HISTORY

Are you presently under the care of a physician? Yes No
If so, name and address:

State you general health in you own words:

PAST HISTORY

List medications you are presently taking:

Do you have any allergies? Yes No
If so, list:

Previous surgery? Yes No
If so, list:

Hospital admissions Yes No
If so, list:

Have you ever had or do you now have:

Yes	No	Diabetes
Yes	No	Heart disease
Yes	No	High blood pressure
Yes	No	Cancer
Yes	No	Asthma
Yes	No	Arthritis
Yes	No	Epilepsy
Yes	No	Fractures/dislocations
Yes	No	Hepatitis
Yes	No	Blood clots in legs
Yes	No	Stomach ulcers
Yes	No	Anesthesia reaction
Yes	No	Osteoporosis

FOR WOMEN ONLY

Are you pregnant? Yes No

FAMILY HISTORY

Do any of your parents, brothers, sisters and or children have any of the following:

Yes	No	Heart disease
Yes	No	Diabetes
Yes	No	Cancer
Yes	No	Arthritis

SOCIAL HISTORY

Yes	No	Do you smoke? _____ packs/day
Yes	No	Do you drink alcohol?
Yes	No	Has your partner ever harmed or threatened to harm you or someone you love?
Yes	No	Have you ever been physically hurt in an intimate relationship?

REVIEW OF SYSTEMS

Have you ever had or do you now have:

Constitutional

Yes	No	Unexplained fever
Yes	No	Unexplained weight loss or gain

Eyes, Ears, Nose & Throat

Yes	No	Worsening vision
Yes	No	Loss of hearing
Yes	No	Ringing in the ears

Cardiovascular

Yes	No	Chest pain
Yes	No	Palpitations of the heart
Yes	No	Swelling of the ankles or feet

Respiratory

Yes	No	Cough
Yes	No	Difficulty breathing

Gastrointestinal

Yes	No	Upset stomach
Yes	No	Constipation
Yes	No	Blood in the stool

Genitourinary

Yes	No	Blood in the urine
Yes	No	Pain during urination

Endocrine

Yes	No	Urinary frequency
Yes	No	Sugar or protein in the urine

Musculoskeletal

Yes	No	Muscle weakness
Yes	No	Joint stiffness

Skin

Yes	No	Skin rashes
Yes	No	Itching

Neurological

Yes	No	Numbness
Yes	No	Tingling
Yes	No	Dizziness or fainting spells

Psychiatric

Yes	No	Anxiety
Yes	No	Depression

Hematologic

Yes	No	Excessive bleeding
Yes	No	Easy bleeding

ORTHOPEDIC CENTER OF TITUSVILLE

MEDICATIONS

PLEASE PRINT

DATE: ____________

PATIENT NAME: ____

PATIENT DATE OF BIRTH: _______________

PATIENT PRIMARY DOCTOR: ____

PATIENT PHARMACY AND LOCATION: ____

PHARMACY PHONE NUMBER: __________________

LIST ALLERGIES TO MEDICATIONS	LIST ALLERGIC REACTION TO THE MEDICATION

CURRENT LIST OF MEDICATIONS	MILLIGRAMS	DOSAGE