The Methodist Hospital Center for Orthopedic Surgery
Patient History Form
It is very important that you fill in all the blanks on this form.

Date: _____

Full Name: _____Preferred Name: _____

Phone#:_____Email:_____

Race: White ____ Black ____ Hispanic ____ Asian ____ Other ___

Birthdates: _____ Age: _____ M ___ F___ Height: _____ Weight: _____

Occupation: _____

Who referred you to our office? _____PCP/Internist_____

Specialist: _____Cardiologist_____

Live: Alone ___ With Others ___ 1 __ 2__ story home Supervised Setting _____

Tobacco Use: Never __Cigarettes __ Cigars ___Chewing Tobacco ____ packs per day_____?

Alcohol use No ___ Yes ___ drinks per week_____?

If student:
Name of School: _____
Sport: _____
Position: _____

Why are you seeing us today? When and how did the problem begin?

Left / Right **Shoulder** Left / Right **Elbow** Left / Right **Hip** Left / Right **Knee**

_____

_____

_____

Was this injury due to a work related accident? Yes ___No ___ Motor Vehicle Accident? Yes ____No____

Do you have an Attorney? Yes _____No____ if yes, name of attorney_____

Pain on a level of 1-10____
What relieves pain: Standing/Walking/Rest?
What worsens pain: Standing/Walking/Rest?

Do you have any current medical conditions?

___ **Blood Clots or DVT**
___ **Pulmonary Embolism**
___ **Diabetes**
___ **Bleeding Problems**
___ Heart Disease
___ High Blood Pressure
___ Stroke
___ Cancer (type) _____
___ HIV
___ Hepatitis
___ Thyroid Problem
___ Kidney Problem
___ Asthma/Emphysema
____ Other _____
_____
_____

What surgical operations have you had?

	When	Type of Surgery	Surgeon
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Have you ever had any complications during surgery or from the anesthesia? No_____ Yes_____

What medications/Vitamins/Herbs/Diet Pills or over the counter medications are you currently taking? (Please include dosage and how often it is taken)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

DO YOU HAVE ANY DRUG ALLERGIES? No ___ Yes____ (Explain) _____

_____

Have you or an immediate family member (parents, siblings, and children) ever was diagnosed with:

	You	Family		You	Family
Stroke	____	____	Wound Healing Problems	____	____
Seizures /Neurological Probs.	____	____	Diabetes	____	____
Eye Problems	____	____	HIV	____	____
Ear, Nose, Throat Problem	____	____	Thyroid Problems	____	____
Breathing Problems	____	____	Gout	____	____
Asthma/Emphysema	____	____	Pseudogout	____	____
Heart Disease	____	____	Gall Bladder Disease	____	____
Other Heart Problems	____	____	Gum Disease/Tooth Abscess	____	____
High Blood Pressure	____	____	Prostate Problems	____	____
Kidney Problems	____	____	Urine Incontinence	____	____
Hepatitis/Liver Problems	____	____	Tuberculosis	____	____
Ulcers/Abdominal Problems	____	____	Acid Reflux	____	____
Bleeding Disorder/DVT	____	____	Skin Problems	____	____
Skin Problems	____	____	Musculoskeletal Problems	____	____
Sudden Weight Loss/Gain	____	____	Rheumatoid Arthritis	____	____
Psychiatric Problems	____	____			

Review of Systems
Circle all that apply:

General:	Wt loss/gain, fever, chills
Eyes:	Pain, Discharge, Redness, Glasses
Head/Mouth/Nose/Throat:	Sore Throat, Nasal Discharge, Hoarseness, Ringing in Ear, Hard of Hearing, Hearing Aids.
Respiratory:	Wheezing, Cough, Shortness of Breath, Sputum, Coughing Blood
Cardiovascular:	Chest Pain, Diaphoresis, Fainting, Foot Swelling, Heart Surgery
Gastrointestinal:	Acid Reflux, Gastric Ulcer, Peptic Ulcer, Diverticulitis, Irritable Bowel, Diarrhea, Bleeding, Urinary Frequency, Incontinence, Blood in Urine, Enlarged Prostate.
Neurologic:	Headache, Confusion, Slurred Speech, and Dizziness
Musculoskeletal:	Joint Swelling, Joint Pain, Joint Redness, Muscle Weakness, and Walker/Cane.
Breast:	Abscess, Discharge, Cancer
Endocrine:	Menstrual Irregularity, Excessive Sweating/Thirst/Hot/Cold.
Hematologic/Lymphatic:	Sickle Cell, Sickle Cell Trait, Hemophilia, Blood Clots, and Pulmonary Embolisms.
Allergies/Immune System:	Hay Fever, Sinus, Food Allergies, Immunosuppressive.

I have read and truthfully answered each question to the best of my knowledge:

_____

Patient/Guardian signature **Date**

Reviewed by: _____ **Date:** _____