PATIENT HISTORY FORM

DEMOGRAPHICS

Date: _____/_____/_____ Email:_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age: _____ Sex: ❑ F ❑ M Occupation: _____ Pharmacy: _____
No Walgreens or Walmart

Date of injury:

Describe how you were injured:

Please list treating physicians, therapists, and treatment to date:

Height: _____ Weight: _____

Have you injured this body part before? _____

Have you injured the other side before? _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ Cancer (type) _____
❑ Hepatitis C
❑ MRSA
❑ Heart problems
❑ Sleep Apnea
❑ Pulmonary embolism/blood clots
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Kidney disease
❑ Crohn's disease
❑ Colitis
❑ HIV/AIDS
❑ Stomach or peptic ulcer
❑ Anesthesia Complications

Other medical conditions (please list) _____

PAST SURGICAL HISTORY Please list all surgeries you have had:

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes Please list:

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health Problems	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

SOCIAL HISTORY

1. Do you smoke tobacco? _____ packs per day: _____ How long: _____
2. Do you drink alcohol: _____ Drinks per day: _____ Abuse history: _____ withdrawal? _____
3. Do you use marijuana: _____ amount per week?
4. Do you use drugs now: _____ in past _____?

Hobbies _____
Sports: _____
Marital Status: _____ Children: _____

SYSTEMS REVIEW

Please mark any of the following you are currently experiencing:

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

BLOOD
- ❑ Anemia

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Vomiting
- ❑ Constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

PSYCHIATRIC
- ❑ Anxiety
- ❑ Depression

CONSENT TO USE OR DISLCOSE MEDICAL INFORMATION

I authorize Occupational Orthopedics, LLC to use and disclose my health and medical information for the following purposes:

- **Treatment:** Use by our providers and staff, coordinating care with other medical providers, work compensation carrier, and disability insurance companies.
- **Payment:** Including authorization, scheduling billing and payment, review for medical necessity, justification of charges, pre-certification and prior authorization.
- **Healthcare Operation:** Includes the usual administrative and business functions of our office

I understand that I have the right to revoke or restrict this consent provided that I do so in writing, except to the extent that Occupational Orthopedics LLC, has already used or disclosed the information in reliance to this consent.

_____ _____ _____
Patient Name (Please Print) Signature of Patient or Representative Date