

# ARTHRITIS & SPORTS

## ORTHOPAEDICS & PHYSICAL THERAPY

### Patient History

Please answer all questions.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(First, Middle, Last)

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ How did you hear about this practice?  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Please include first and last name

ALLERGIES: \_\_\_\_\_ Physician location: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

### PRESENT MEDICATIONS (list all)

Name	Dose	Frequency	Reason
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Specific reason for seeing Orthopedic Surgeon: 1. \_\_\_\_\_

\_\_\_\_\_ 2. \_\_\_\_\_

Symptoms began: \_\_\_\_\_ 3. \_\_\_\_\_

\_\_\_\_\_ 4. \_\_\_\_\_

\_\_\_\_\_ 5. \_\_\_\_\_

\_\_\_\_\_ 6. \_\_\_\_\_

### PAST MEDICAL HISTORY

(List any medical problems)

\_\_\_\_\_

\_\_\_\_\_

### SOCIAL HISTORY

Do you smoke? Yes No

If yes, how much \_\_\_\_\_

Do you drink alcohol? Yes No

If yes, how much \_\_\_\_\_

Do you use drugs? Yes No

If yes, name of substance \_\_\_\_\_

### REVIEW OF SYSTEMS

#### HAVE YOU EVER HAD:

(Circle and what year)

Heart Attack Yes No

Irregular Heartbeat Yes No

Heart Failure Yes No

Stomach Ulcers Yes No

Stroke Yes No

High Blood Pressure Yes No

Diabetes Yes No

Kidney Disease Yes No

Joint Pain Yes No

Emphysema Yes No

Hepatitis Yes No

Difficulty Urinating Yes No

Epilepsy/Seizures Yes No

Abnormal Bleeding Yes No

Anemia Yes No

Drug Reaction Yes No

Anesthetic Reaction Yes No

Cancer Yes No

### FAMILY HISTORY

Heart Disease Yes No

Diabetes Yes No

Anesthetic Reaction Yes No

Cancer Yes No

Arthritis Yes No

Other: \_\_\_\_\_

### PREVIOUS SURGICAL HISTORY

Procedure	Date	Complications
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

### MEDICAL RECORDS RELEASE

I authorize and request the release of my medical records to:

1-Family Physician: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

2-Other Physician: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

List below those individuals (family, friends, interpreter, etc.) you will allow disclosure of your personal health information from Arthritis and Sports Orthopaedics as necessary during the course of your health care services:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_