ORTHOPAEDIC SPECIALISTS OF AUSTIN

MEDICAL HISTORY

PATIENT NAME:		DATE:	
Patient's Date of Birth:			
Referring Doctor:		Phone:	
Address:			
Family Doctor:		Phone:	
Address:			
☐ Right-Handed ☐ Left-Handed	Weight:	Height:	Age:

HISTORY OF PRESENT ILLNESS

Reason for your visit:	
Is this the result of an injury? Yes / No (circle one)	
If Yes, did the injury occur while at work? Yes / No (circle one)	
Date of injury:	Location of injury:
How did injury occur?	

EVALUATION OF PAIN / DISCOMFORT

What body part(s) is/are affected:											
When did the problem start?											
When does the problem occur?											
What makes it feel better?											
What makes it feel worse?											
How long does it last?											
Pain Scale		MILD			MODERATE				SEVERE		(Circle a number)
NO PAIN	1	2	3	4	5	6	7	8	9	10	
What activities are you unable to do because of pain?											
Does the pain wake you from sleep? Yes / No											Is the pain activity-related? Yes / No

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing (circle all that apply) X-Rays CT MRI EMG Other:_____

Medications taken (past or current) for this problem:

Anti-Inflammatories	☐ Helpful	☐ Not Helpful	Other treatment(s) for this injury:
Injections	☐ Helpful	☐ Not Helpful	
Physical Therapy	☐ Helpful	☐ Not Helpful	
Chiropractics	☐ Helpful	☐ Not Helpful	
Acupuncture	☐ Helpful	☐ Not Helpful	

Have you seen other doctors for this condition? Yes / No If Yes, who?_____

Is this condition being covered by Worker's Compensation? Yes / No

Is there a lawsuit or litigation pending in regard to this condition? Yes / No

PAST MEDICAL HISTORY (check all that apply)

☐ Diabetes	☐ Bleeding tendencies	☐ HIV / AIDS
☐ High blood pressure	☐ Blood clots	☐ Hepatitis
☐ Stroke	☐ Cancer	☐ Vascular Disease
☐ Heart disease	☐ Ulcers	☐ Anesthesia difficulties

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PAST SURGICAL HISTORY			
Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:

MEDICATIONS (please list all prescription and non-prescription medications that you are currently taking)					
Medication Name	Dose	How often	Medication Name	Dose	How often

ALLERGIES (medications, metals, etc.)
List:

FAMILY HISTORY (check all that apply)		
☐ Cancer	☐ Diabetes	☐ Musculoskeletal disease
☐ Heart disease	☐ Malignant hyperthermia	☐ Anesthesia difficulties
☐ Stroke	☐ Bleeding disorder	

SOCIAL HISTORY (check all that apply)			
☐ Married	☐ Single	☐ Divorced	☐ Widowed
☐ Live alone	☐ Live with family	☐ Live with friends	☐ Live in nursing home
Do you smoke: Yes / No	How many packs/day?		How many years?
Alcohol consumption: ☐ None	☐ Minimal	☐ Moderate	☐ Heavy
Occupation:		Last day worked:	

REVIEW OF SYSTEMS (check all that apply)							
Skin	☐	Rash	Throat	☐	Sore throat	GI	☐ Weight loss or gain
	☐	Psoriasis		☐	Hoarseness		☐ Abdominal pain
Heme	☐	Bleeding tendencies		☐	Snoring		☐ Liver disease
	☐	Bruise easily	CV	☐	Heart attack		☐ Constipation
Eyes	☐	Visual loss		☐	Irregular heartbeat	GU	☐ Kidney stones
	☐	Double vision		☐	Chest pain or pressure		☐ Bladder infections
Ears	☐	Decreased hearing	Lungs	☐	Shortness of breath		☐ Blood in urine
	☐	Ringing in ears		☐	Asthma	Endo	☐ Diabetes
Nose	☐	Sinus probs		☐	Bronchitis		☐ Thyroid
	☐	Breathing probs		☐	Pulmonary emboli / DVT	Skeletal	☐ Osteoporosis
Psych	☐	Depression	Neuro	☐	Seizures		☐ Rheumatoid Arthritis
	☐	Hallucinations		☐	Headaches		☐ Gout