OVERTURF
ORTHOPEDICS

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## Patient History

Name: Date:

Age: DOB: Sex: M F (circle one) Height: Weight:

Hand Dominance: RT LT Both

Referring MD: Primary Care Physician:

Drug Allergies:

Pharmacy: Cardiologist: Blood Thinner: YES NO

Current Medications:

### History of present illness/injury (reason for your visit)

Reason for Visit:

Date of Onset (WHEN DID IT HAPPEN)

Mechanisim of Injury (HOW DID IT HAPPEN)

**DESCRIPTION OF PAIN:**

**LOCATION:**

**QUALITY**: shooting throbbing sharp burning aching tenderness

**SEVERITY** (scale 0=minimal / 10=extreme) 0 1 2 3 4 5 6 7 8 9 10

**Duration**: constant frequent sometimes

**SYMPTOMS**: swelling bruising numbness tingling grinding popping

What makes it better?

What makes it worse?

**TIMING**:

- How often does it happen? : During each day/week/ month
- Is it occurring: More often / Less often/ Can't say
- Associated with any other symptom or complaint?
- Mainly at Night/ During the Day/ In the Morning/

Is it associated with any particular activity? YES/ NO

If YES, Explain:

### PRIOR TREATMENT FOR THIS PROBLEM( INCLUEDE DATES)

Physician/ Hospital:

Medication/ Injections:

Physical Therapy:

Diagnostic Test:


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# Review of Systems

Do you have or have you had any of the following?

Name: _____

**Constitutional:**

| | | |
|---|---|---|
| Fever | Yes | No |

**Eyes:**

| | | |
|---|---|---|
| Double Vision | Yes | No |

**ENMT:**

| | | |
|---|---|---|
| Hearing loss | Yes | No |

**Respiratory:**

| | | |
|---|---|---|
| Shortness of Breath | Yes | No |

Gastrointestinal:

| | | |
|---|---|---|
| Nausea | Yes | No |
| Vomiting | Yes | No |

**Skin:**

| | | |
|---|---|---|
| Rash | Yes | No |

**Musculoskeletal:**

| | | |
|---|---|---|
| Limited Motion | Yes | No |
| Joint Pain | Yes | No |

**Neurological:**

| | | |
|---|---|---|
| Numbness/ Tingling | Yes | No |

**Cardiovascular:**

| | | |
|---|---|---|
| Swelling | Yes | No |

**Hematologic:**

| | | |
|---|---|---|
| Blood Clot | Yes | No |

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Name: _____

**Past Surgeries & Dates:**

| |
|---|
| |
| |
| |
| |

**Social History**

| | | | | | |
|---|---|---|---|---|---|
| Alcohol | Never | Social | Frequent | Type? | Quit?/When? |
| Drug use | Never | Occasional | Frequent | Type? | Quit?/When? |
| Exercise | Never | Occasional | Moderate | Heavy | |
| Tobacco | Never | Packs/Day | | Smokeless | Quit/When? |
| Military | Active | Inactive | None | | |
| Marital Status | Single | Married | Divorced | Widowed | |

**Immediate Family Medical History (circle all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | Yes | No | HIV/AIDS | Yes | No |
| Respiratory Problems | Yes | No | Heart Trouble | Yes | No |
| Bleeding Problems | Yes | No | Cancer | Yes | No |
| Diabetes | Yes | No | Other Problems:_____ | | |
| Stroke | Yes | No | | | |

**Patient Medical History (circle all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| Abdominal Problems | Yes | No | Hepatitis | Yes | No |
| Anesthesia Problems | Yes | No | Hormone Abnormalities | Yes | No |
| Asthma | Yes | No | Hypertension | Yes | No |
| Bleeding Problems | Yes | No | Kidney Stones/Disease | Yes | No |
| Blood Clots | Yes | No | Lung Disease | Yes | No |
| Bowel Problems | Yes | No | Muscle Disease | Yes | No |
| Breast Lumps/Pain | Yes | No | Neurologic Disease | Yes | No |
| Bronchitis | Yes | No | Stroke | Yes | No |
| Cancer | Yes | No | Wound Healing Issues | Yes | No |
| Cataracts | Yes | No | Diabetic | Yes | No |
| Convulsions/Seizures | Yes | No | | | |
| Coronary Artery Disease | Yes | No | | | |
| Gerd | Yes | No | | | |
| Good General Health | Yes | No | | | |
| Heart Disease | Yes | No | | | |