HENDRICKS REGIONAL HEALTH SPORTS MEDICINE

HENDRICKS ORTHOPEDICS & SPORTS MEDICINE

Patient History Form

Name: _____ Birth Date:____/_____/_____

Please describe reason for coming_____ Body Part _____ ○ Right ○ Left ○ Both

○ New Injury ○ Chronic Symptoms When/How did symptoms begin_____

Injury Resulting from: ○ Sports ○ Accident ○ Work Related ○ Involving Litigation

Allergy Information

Any drug allergies ○ Yes ○ No Allergic to Latex ○ Yes ○ No

If so, please list the drugs and type of reaction (example: rash, nausea, etc.) PLEASE BE SPECIFIC

_____

Medication Information

List any current medications that you are taking at this time. Please include over the counter medications, vitamins, herbs, etc. (If you have a list, we can copy it)

Name of Medication	**Dose** (Include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Past Surgical /Hospitalization History

Previous Surgery/Hospitalization	**Year**
1.	
2.	
3.	
4.	
5.	

Family Medical History (Please check if a family member has a history of the condition and list the relation of family member with condition)

- ○ Alcohol/Drug Abuse _____
- ○ Arthritis (RA, OA, Gout)_____
- ○ Bleeding Disorder_____
- ○ Cancer(Type:)_____
- ○ Diabetes_____
- ○ Glaucoma_____
- ○ Heart Disease _____
- ○ High Blood Pressure _____
- ○ Death before 50 _____
- ○ Marfan Syndrome_____
- ○ Mental Illness_____
- ○ Stroke_____

Please Turn over and complete the back of the form

Social History

Married/Single Do you live alone? ○ Yes ○ No If no, who do you live with?_____

Do you exercise regularly ○ Yes ○ No Please describe activities_____

Occupation_____ Number of Years_____ Job Duties_____

Dominant Hand: ○ Right ○ Left Do you use a seatbelt on a regular basis ○ Yes ○ No

Tobacco Use? ○ Yes ○ No Type:_____ Amount per day_____ Number of years used_____

Alcohol Consumption? ○ Yes ○ No Number of drinks/week: _____ History of Alcoholism ○ Yes ○ No

Recreational/ Drug Use? ○ Yes ○ No Type/Amount/How often:_____

Medical History/Review of Systems

Please check if you have a history of the following:

Psychological
- ○ Anxiety Disorder
- ○ Depression
- ○ Other

Urology
- ○ History of Kidney Disease
- ○ Urinary Infection
- ○ Hematuria (Blood in Urine)
- ○ Jaundice

Infectious Disease
- ○ Hepatitis
- ○ Immune Disorder
- ○ Mononucleosis

Dermatology
- ○ Skin Problems Type:

Female Reproductive
- ○ Currently Pregnant

Date of first menstrual cycle:_____

Date of last menstrual cycle:_____

Longest time between periods:_____

Cardiovascular
- ○ High blood Pressure/hypertension
- ○ Heart attack/ Myocardial Infarction
- ○ Ankle Swelling
- ○ Chest Pain/Angina
- ○ Palpitations
- ○ Shortness of Breath
- ○ Heart Murmur

Constitutional
- ○ History of Cancer
- ○ Fatigue
- ○ Fever
- ○ Weight Change
- ○ Anorexia or Bulimia
- ○ Hernia

Endocrinology
- ○ Thyroid Problems
- ○ Diabetes

ENT
- ○ Dental Infection
- ○ Eye Trouble
- ○ Hearing Loss

Gastroenterology
- ○ Ulcers

Hematology
- ○ Blood Clots
- ○ On Blood Thinners
- ○ Bruise/Bleed Easily
- ○ Anemia

Musculoskeletal
- ○ Muscle Weakness
- ○ Gout
- ○ Infection in extremities
- ○ Arthritis Type:
- ○ Osteoporosis
- ○ Previous Bone Density Test
- ○ Joint Pain
- ○ Joint Swelling
- ○ Previous Fracture

Neurological
- ○ Muscle Spasms
- ○ History of Stroke
- ○ Dizziness/Fainting
- ○ Headache
- ○ Epilepsy
- ○ Tingling/Numbness
- ○ Concussion

Respiratory
- ○ TB Exposure
- ○ History of asthma/lung disease
- ○ Chronic Cough