SOCIAL HISTORY

Do you smoke? YES___ NO___

Do you drink alcohol? YES___ NO___

What is your marital status?

Single Married Divorced Widowed

Do you have children? YES___ NO___

If yes, how many _____

In what type of residence do you live? _____

_____

Are there stairs in your home? YES___ NO___

Do you live alone? YES___ NO___

If no, with whom do you live _____

_____

What are your hobbies and / or recreational activities? _____

_____

REVIEW OF SYSTEMS

Please indicate if you have any of the following problem(s): (Circle all that apply)

General: fever, chills, sweats, fatigue, malaise, weight loss

Eyes: blurring, double vision, irritation, discharge, vision loss (one eye; both eyes), eye pain, sensitivity to light, halos

Ear / Nose / Throat: earache, ear discharge, ringing in ears, decreased hearing, nasal congestion, nosebleeds, sore throat, hoarseness, difficulty swallowing

Cardiovascular: difficulty breathing at night, short of breath on exertion, shortness of breath when lying down, fatigue, racing of the heart, chest pain, leg cramps with exertion

Respiratory: cough, difficulty breathing, excessive sputum, coughing up blood, wheezing

Gastrointestinal: vomiting blood, indigestion, nausea, vomiting, abdominal bloating, gas, hemorrhoids, diarrhea, constipation, change in bowel habits, blood in stool, dark tarry stools

Genitourinary: blood in urine, unusual color of urine, painful urination, foul smelling urinary discharge, inability to control bladder, urinary urgency, urinary frequency

Musculoskeletal: back pain, joint pain, joint swelling, presence of joint fluid, muscle cramps, muscle weakness, stiffness, arthritis, gout, decreased strength

Skin: rash, itching, dryness, suspicious lesion(s)

Neurological: headaches, visual disturbances, poor coordination, poor balance, numbness, tingling, weakness, seizures, tremor

Psychological: depression, anxiety, memory loss, mental disturbances, suicidal ideation, hallucinations, paranoia

Endocrinology: cold intolerance, heat intolerance, increased thirst, increased appetite, increased urination, weight changes

Hematology / Lymphatic: abnormal bruising, bleeding, enlarged lymph nodes, fevers

Allergy / Immunology: hives, hay fever, persistent infections, HIV exposure

ADDITIONAL INFORMATION: _____

_____

AGE ____ SEX: M ___ F ___ HT ___ WT ____

FAMILY PHYSICIAN: _____

REFERRED BY: _____

CHIEF COMPLAINT: (example: right knee pain)

_____

_____

DETAILED DESCRIPTION – GIVE DATE OF ONSET AND SYMPTOMS OF ACCIDENT/PROBLEM:

_____

_____

_____

_____

_____

(If additional space is needed, use back side of form)

HAVE YOU PREVIOUSLY BEEN TREATED FOR THIS PROBLEM? YES___ NO___

If "yes," please indicate below:

Where When

_____

Emergency Room _____

Family Physician _____

Orthopedic Surgeon _____

WERE X-RAYS TAKEN? YES___ NO___

If "yes," please indicate below:

Where When

_____

HAVE YOU PREVIOUSLY HAD SURGERY FOR THIS PROBLEM? YES___ NO___

If "yes," please indicate below:

Where When

_____

_____

ARE YOU CURRENTLY EMPLOYED? YES___ NO___

ARE YOU RETIRED? YES___ NO___

OCCUPATION (if retired, previous occupation)

_____

ARE YOU CURRENTLY NOT WORKING DUE TO YOUR ILLNESS OR INJURY? YES___ NO___

- NP – history

PATIENT LABEL

PAST MEDICAL HISTORY

ORTHOPEDIC SURGICAL HISTORY: _____

_____

_____

_____

FRACTURES: _____

_____

OTHER SURGERIES: _____

_____

_____

MEDICAL CONDITIONS / ILLNESSES: _____

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

_____

ALLERGIES: _____

_____

FAMILY MEDICAL HISTORY

ANY KNOWN DISEASES OCCURRING IN YOUR FAMILY? _____

_____

_____

FATHER:

Still Alive? YES___ NO___

If no, cause of death: _____ Age: _____

MOTHER:

Still Alive? YES___ NO___

If no, cause of death: _____ Age: _____

PLEASE TURN PAGE OVER TO COMPLETE THIS FORM