EHOSM
EAST HOUSTON ORTHOPEDICS & SPORTS MEDICINE

PATIENT HISTORY

PATIENT NAME _____ **DATE** _____

Age _____ Height _____ Weight _____

PRESENT ILLNESS / INJURY / SYMPTOMS

What is the nature of your illness, injury or symptoms? _____
(back pain, hurt foot, shoulder pain, etc. Please specify Right, Left or Both)

Did you have an Accident or Injury to cause your symptoms? ☐ YES ☐ NO

If YES, state where it happened *(CIRCLE one)* WORK HOME AUTO OTHER *(specify)* _____

Date of Accident / Injury or Onset of Symptoms *(month/day/year)* _____

If Accident / Injury, please explain how you were injured _____

_____

_____

_____

Have you received treatment for this problem? ☐ YES ☐ NO

If YES, who provided treatment? _____

Where? _____ When? _____

Were x-rays or other tests performed? ☐ YES ☐ NO

If YES, what tests were performed? _____

Where? _____ When? _____

REQUIRED - WORK RELATED INJURIES

Were you able to continue work on day of Accident / Injury? ☐ YES ☐ NO

Are you currently working? ☐ YES ☐ NO

If NO, what was the last day you worked? _____

Are there any current work restrictions? ☐ YES ☐ NO

If YES, please specify _____

Are you planning to return to full duty at work? ☐ YES ☐ NO

Are you currently involved in a legal action for this injury? ☐ YES ☐ NO

If YES, attorney's name & telephone number _____

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following conditions? *(Please CIRCLE all that apply).*

High Blood Pressure	Kidney Problems	Diabetes	Stroke	Asthma	Emphysema
Blood Clots (DVT)	Psychiatric Illness	Arthritis	Gastritis/Ulcers	Cancer	Heart Problems

Other *(please specify)* _____

PAST SURGICAL HISTORY

Please list any OPERATIONS / SURGERIES / PROCEDURES you have had including DATES and PHYSICIAN / SURGEON.

_____

_____

_____

FAMILY MEDICAL HISTORY

Do any of your immediate relatives have any of the following conditions? *(Please CIRCLE all that apply).*

High Blood Pressure	Kidney Problems	Diabetes	Stroke	Asthma	Emphysema
Blood Clots (DVT)	Psychiatric Illness	Arthritis	Gastritis/Ulcers	Cancer	Heart Problems

Other *(please specify)* _____

SOCIAL HISTORY

Do you have any children? ☐ YES ☐ NO If YES, how many? _____

Do you live alone? ☐ YES ☐ NO

Do you have a Living Will? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO If YES, frequency? _____

Do you drink alcoholic beverages? ☐ YES ☐ NO If YES, average # drinks per week? _____

Do you exercise? ☐ YES ☐ NO

If YES, what type of exercise & how often? _____

Do you now or have you ever used "street" drugs? ☐ YES ☐ NO

If YES, please list _____

ALLERGIES

Are you allergic to any medication(s)? ☐ YES ☐ NO

If YES, list medication(s) and type of reaction _____

_____

CURRENT MEDICATIONS

Please list ALL medications you are currently taking, including doses.

_____

_____

_____

_____

_____

_____

_____

_____

_____

MISCELLANEOUS

Please list any other information you think we need to know to assist you with your injury or musculoskeletal complaint.

_____

_____

_____

To the best of my knowledge, questions on this form have been answered accurately. I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the physician of any changes in my medical status.

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **ACCT#** *(office use)*